DEPARTMENT OF HEALTH AND HUMAN SERVICES
PUBLIC HEALTH SERVICE
INDIAN HEALTH SERVICE
ROCKVILLE, MARYLAND 20857 Refer To: OHP

INDIAN HEALTH SERVICE CIRCULAR No. 95-16

CREDENTIALS AND PRIVILEGES REVIEW PROCESS FOR THE MEDICAL STAFF

Sec.

1. PURPOSE.

This Indian Health Service (IHS) Circular establishes the elements of credentials review required for application or reapplication for medical staff membership and/or clinical privileges at IHS facilities. It is applicable to both hospital and ambulatory care settings.

This Circular does not address any additional elements that may be required for employment or contract affiliations. Questions on these matters may be directed to the Area Physician Recruiters or Area Contracting Officers.

Recommended procedures and forms are appended to assist in the effective and efficient implementation of this policy.

2. DEFINITIONS.

A. Medical Staff: The term "medical staff" shall include physicians (M.D. and D.O.), dentists, and possibly other health care providers who are licensed or otherwise permitted by a State and by the health care facility to provide patient care services independently within the scope of the profession and in accordance with individually granted clinical privileges. The medical staff may include, therefore, psychologists,

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optometrists, podiatrists, audiologists, certified nurse midwives, certified registered nurse anesthetists, nurse practitioners , physician assistants, and other health professionals, if they are licensed and permitted by the facility to function as independent practitioners. The composition of the local medical staff is left to the discretion of that medical staff and its governing body. For all hospitals, the majority of the Executive committee of the Medical Staff shall be actively practicing physicians.

B. Categories of Medical Staff The following categories of the medical staff are to be used as a guide, but are not restrictive:

(1) Provisional Those new members of the medical staff who are serving a required probationary period as specified in the local medical staff bylaws. During this time their qualifications for membership on the active or courtesy medical staff are assessed. In the IHS, depending on the local medical staff bylaws, provisional active members may be permitted to vote at medical staff meetings, whereas provisional courtesy members may not. The staff member shall be deemed "Provisional-Active" or "Provisional-Courtesy."

(2) Active: Those members who are either IHS employees or employees of Public Law (P.L.) 93-638 tribal contractors who spend a large proportion of their professional time within the-IHS facility and/or service unit. They have served their probationary period and have been found to be fully qualified for membership on the medical staff. Active staff members may vote at medical staff meetings.

(3)Temporary: Those members who provide services on a short-term basis or who have applied for active medical staff membership, but await a full credentials review. They are not eligible to vote at medical staff meetings.

(4) Courtesy or Associate: Those members who generally provide services on a periodic or episodic basis (e-g., hold specialty clinics, provide laboratory consultation, or serve as a radiologist) and are frequently not IHS employees. An IHS Area consultant, who occasionally visits a service unit to see patients may join the courtesy staff, but is not eligible to vote at medical staff meetings.

c. verification: During the course of a credential review, the information obtained from an applicant shall be verified through the use of letters, phone calls, or state licensing board computer printouts. (Follow current Joint Commission on Accreditation of Healthcare Organizations (JCAHO) Scoring Guidelines). Primary - source verification is required of certain ,credentials, such as, professional education, post graduate training, and licensure. Secondary verification, available through data banks such as the American Medical Association Master File, may be helpful but must be considered supplementary. All applicants will be checked against the National Practitioner Data Bank (NPDB); additionally the NPDB must be queried for all medical staff at least every two years.

3. BACKGROUND.

Within the IHS, the credentials review process and the granting of clinical privileges evolved over the years to include a variety of methods with some variation in the quality of review. While content and procedural variations from Area to Area or service unit to service unit may have reflected local needs, ingenuity, or innovation, the variations presented an obstacle to the IHS in its effort to assure itself, the Congress, local communities, and it's patients that IHS providers are qualified and meet acceptable standards of practice.

For these reasons, this policy was developed to standardize the contents of credentials review in the IHS and to provide recommended procedures and sample forms which will assist in complying with the policy. Local variations are possible, so long as the content and sequence adhere to the requirements set forth in the policy. Local variations of the privileges request forms are encouraged, since only those privileges that can be supported by the facility should be listed.

Today, all health service delivery components of the IHS are responsible for ensuring that:

A. The initial review and verification of a provider's credentials to determine eligibility for medical staff membership and proper assignment have been performed.

B. Health care providers are qualified and competent to deliver quality health services consistent with those of the medical community at large.

c. The facility specific privileges that each provider is granted are clearly delineated.

D. Providers credentials and privileges are reassessed and re-certified on a regular basis.

E. The needs of the medical staff relative to patient load and diagnostic mix, and the ability of the facility to provide adequate support facilities, services, and staff are met.

In addition, IHS policy requires facilities to meet the accreditation standards of the JCAHO. The current JCAHO standards for accreditation include the following:

A. Providing for the possible expansion of medical staff membership.

B. Establishing comprehensive policies and processes for the credentialing and delineation of clinical privileges in order to:

(1) Ensure the qualification and the current clinical competence of health care staff.

(2) Improve the quality and appropriateness of health care.

4. POLICY.

It is the policy of the IHS that all individuals who are eligible for membership on the medical staff, must have a documented, current review of their medical staff credentials. This includes individuals who provide direct, independent, and unsupervised patient care services in IHS facilities or under IHS auspices.

5. PROCEDURES.

The applicant for medical staff membership and/or clinical privileges must undergo a credentials review before delivering health care services to any patient. Clinical privileges may be granted through procedures outlined in local medical staff bylaws.

(Note: Special arrangements for temporary medical staff who, join the medical staff on short notice. See Section 5.E)

The appendices to 'this Circular provide specific guidance and sample-forms to assist in the review of credentials for purposes of granting medical staff membership and/ok clinical privileges. These procedures and forms are not required, 'but they do meet the requirements of this policy. Area or service unit variations in either the process" or the forms used in credentials review should be assessed to ensure compliance with the policy and with JCAHO accreditation requirements. The clinical privileges request forms are to be tailored to the facility,-since the facility must have the capacity to support a clinical privilege that 'is granted. Privileges that cannot be supported should not be included in privileges request forms. If the appended procedures and forms are used in conjunction with the requirements of -the. hiring process, a very complete and valuable credentials, review can be carried out.

A. Required Elements Review The credentials review process must, at a minimum,, address the following areas, noting the special considerations in each..

All information requires verification of:

(1) Professional: All medical staff members, and those practitioners who fall under the aegis of the medical staff, must possess a diploma as a graduate of a professional school, accredited by a nationally-recognized accrediting body, appropriate for the member's professional discipline. The foreigngraduate must possess a diploma as a graduate of a professional school and documentation of having successfully completed appropriate certifying requirements, e.g., ECFMG and/or the 'Federal Licensing Examination," (FLEX) for physicians, as applicable to the specific profession.

(2) Post-Graduate Training:

a. All physicians and other medical staff whose professional disciplines require postgraduate clinical training must possess certification of such training in a program accredited by a nationally-recognized accrediting body.

b. Any internships, residencies, fellowships, or other organized professional training which has been completed should be specified, including: dates of participation, location, type of program, and name of program director.

(3) Experience. All elapsed time since graduation from professional school should be accounted for, with a summary of jobs or medical staff memberships, dates, locations; and types of activities or privileges

(d) Professional Affiliations: Any board, certification held by an applicant and any professional association to which an applicant belongs should be noted.

(5) Licensure: All members of the medical staff must hold an active and unrestricted state license, certification, or registration; as applicable, to practice independently in their professional field. The term 'unrestricted,-" means that there are no restrictions, special considerations periods of monitoring, or probation associated with the license, certification, or registration that restricts or inhibits the ability of the practitioner to practice his/her profession in the specialty or clinical area for which the practitioner is being hired. This includes any stipulations that may have a potentially significant adverse impact on the patients, the medical staff, or the efficiency of the facility.

(6) **Suitability** for membershlip ~~and/or gr~~anting clinical **privileges:**

a. All applicants requesting initial appointment to the medical staff and/or clinical privileges must furnish information pertaining to the following (See p. 1, 5-6 of the "Application for Appointment to the Medical Staff"):

(9 Professional liability claims and/or judgments made against them.
(ii) Previous denial or revocation of medical staff membership at another facility.
(iii) Previous reduction, suspension, revocation, voluntary relinquishment, or non-renewal of privileges at another facility.
(iv) Problems with alcohol or drug abuse.
(v) Previous loss, suspension, restriction, denial, or voluntary relinquishment of professional licensure or professional society membership.

b. Unfavorable information pertaining to suitability must be provided to the Area Office Personnel Security Adjudicator.'

C. All applicants for reappointment must have similar suitability criteria reviewed as well.

(7) References: All applicants for initial membership and/or clinical privileges must provide a minimum of two letters of reference from persons who can attest to the applicant's professional judgment, competence, and character. One letter must be from the training program for those applicants just completing professional school or post graduate clinical training. For other applicants, who are currently members of one or more medical Staffs, one letter must be from the chief of staff or departmental chairperson from each hospital where the applicant is on the active medical staff.

(8) Health Status: All applicants, both for initial appointment and reappointment, must be physically and mentally capable of carrying out the required function6 of their medical staff role and the privileges they are requesting.

(9) **Attestations and Release**: Each applicant for initial appointment must sign a "Statement of Understanding and Release" form, SUCh as the one included in Appendix B.

B. Provisional Membership All medical staff members must complete a required provisional membership period as Specified in the medical staff bylaws. To progress from provisional member status to active member status requires an evaluation of professional judgment, competence, and character, as well as evidence of satisfactory participation in the functions of the medical staff as detailed in the medical staff bylaws.

C. Renewal of Membership, Medical staff membership must be limited to no more than two years before a member's credentials are reassessed for consideration of renewal. Renewal is not automatic nor guaranteed.

D. Clinical Privileges Clinical privileges are granted after careful review and consideration of an applicant's credentials. This is done at the time of initial application or reapplication and at any time that modification of privileges is indicated or requested.

No practitioner can hold unlimited privileges. The granting of privileges must reflect the training, experience, and qualifications of the applicant as they relate to the staffing, facilities, and capabilities of the service unit. Recommendation of privileges should be made by the Executive Committee of the Medical Staff

(or its equivalent as defined in the medical staff bylaws) to the chairman of the governing body. This recommendationshould be routed through the Clinical Director and Service Unit Director to the service unit governing body. Clinical privileges are granted after consultation with discipline-specific staff or consultants, as appropriate.

E. Temporary Medical Staff- Applicants for temporary medical staff membership and/or clinical privileges are subject to the same review as other members, with the following exception. Insufficient time may preclude carrying out a full credentials review before the temporary staff applicant begins to provide patient care services. They may provide services prior to a complete review as long as the following has occurred: an application form has been completed; privileges have been requested; both have been reviewed by the Clinical Director (or medical staff officer in charge) and found to be in apparent conformance with IHS standards; and the Service Unit Director has granted temporary privileges until the governing board takes action. The usual Credentials review and approval must then be completed as soon as possible.

F. Responsibillity for Reviews The Clinical Director at each IHS facility is responsible for ensuring that the credentials review process is carried out for every member of the medical staff. The Clinical Director may designate individual6 to assist in the credentials review process.

G. credentials Files

(1) Storage and Maintenance: The staff credentials files are to be distinct from any employment or Contract files, representing instead the professional relationship and responsibility aspects of the members of the medical staff. Information in the credentials files may, however, be derived from employment or contractual files and data. These files are to be located in the service unit; parts or all of this information may also be located in the Area Office.

(2) Access, Safeguards, and Retention: Access to these files is limited to authorized personnel for use in the performance of their official duties. The Area Director and Clinical Director of each facility are designated as System Managers.

The Systems Managers will develop and maintain a list of personnel who are authorized access and a log Of any disclosures Of information from these files. These records are confidential and therefore must be secured at all times. They must be retained at least five years after an individual's termination from the medical staff. Records of unsuccessful applicants for medical staff membership will be retained for three years. All files and related documents will be maintained in accordance with the IHS Records Disposition Schedule.

(3) **Privacy Act Considera ns** These records are to be maintained in the IHS system of records 09-17-0003, published in the ~~Federal Register~~ November 22, 1988, pages 47355-7358. This notice contains the following information which describes this system of records:

a. The name and location of the system.

b. *The* categories of individual6 on whom records are maintained in the system.

c. The categories of records maintained in the system.

d. Each routine use of the record6 contained in the system, including he categories of users and the purpose of such use.

e. The policies and practices of the IHS regarding storage, retrievability, access controls, retention, and disposal of records.

f. The title and business address of the IHS official who is responsible for the system of records.

g. The IHS procedures whereby individuals can be notified at their request, if the system of records contains a record pertaining to them.

h. The IHS procedures whereby, individuals can be notified (at their request), how to access any record pertaining to them that may be contained in the system of records, and how they can contest its content.

The categories of sources of records in the system.

6. SUPERSEDURE

Indian Health Service Circular No. 93-2, 'Credential6 and Privilege6 Review Process for the Medical StafF" dated June 24, 1993.

7. EFFECTIVE DATE.

This IHS Circular is effective upon date of signature by the Director, IHS.

W. C. VANDERWAGEN MD (FOR)

Michael H. Trujillo. M.D., M.P.H
Assistant Surgeon General
Director, Indian Health Service

Procedures for Credentialing and Privileging the Medical Staff

General Guidelines

The medical staff of an Indian Health Service (IHS) facility may be Comprised of physicians, dentists, optometrists, podiatrists, psychologists, audiologists, certified nurse midwives, certified registered nurse anesthetists, nurse practitioners, physician assistants, and other health professionals, if licensed, and permitted by the facility, to function as independent practitioners. They must provide direct patient care in that facility, but need not be employed by the IHS. All persons in these professions who wish to practice at an IHS facility must have their credentials reviewed and apply for clinical privileges at IHS facilities. The composition of the local medical staff is left to the discretion of that medical staff and its governing body.

The credentials review is required for application or reapplication for medical staff membership and/or clinical privileges. The Clinical Director at each IHS facility is responsible for ensuring that the Credentials review and privileging process is carried out.

The credentials review and the privileging process is separate and distinct from the employment process, both must be completed before a medical staff member's entry on duty, and the process must be carried out at intervals established in the medical staff's bylaws, rules, and regulations. In no case can this interval exceed two years. It is important that unfavorable information pertaining to suitability be provided to the Area Office Personnel Security Adjudicator prior to employment, if it is known at that time.

The Executive Committee of the Medical Staff must review these applications and recommend to the Service Unit Governing Body whether the applicants should be granted or denied membership, if applicable, and which specific clinical privileges should be granted. The Service Unit Director (SUD) also reviews the applications and recommends acceptance/rejection of membership and/or granting/denial of privileges to the Service Unit Governing Body. The Service Unit Governing Body will accept or reject the application for medical staff membership and/or grant or deny the requested privileges.

When the Clinical Director of the facility is the applicant for membership or privileges, the Chief of Staff (if such a distinction is made), Assistant Clinical Director, and/or Area Chief Medical Officer must be actively involved, in the credential6 review Process. They must address all functions in the review process that would normally be handled by the Clinical Director.

The following steps should be completed in the specified credentialing and privileging processes:

Initial Credentialing and Privileging

When an independent health care practitioner indicates a desire to join the medical staff and/or obtain clinical privileges at an IHS facility, the following should occur:

1. The Area or service Unit considering the person sends the person a packet containing the medical staff and clinical privileges applications.

2. After the applications are returned, an appropriate person (Area physician recruiter, Clinical Director or designee, Area discipline-specific consultant, quality assurance staff, etc.) reviews them for completeness, then:

    a. Verifies the status of all licenses held with the appropriate State bodies.

    b. Verifies level of training with school, internship, or residency program.

    c. Speaks with references to verify clinical competence, ability to get along with people, physical and mental health status, liability history (malpractice suits or claims filed, whether and how settled) etc.

    d. Provide6 the findings of this initial verification and review to the Clinical Director of the IHS facility considering the applicant for staff membership, certifying the accuracy and authenticity of the information provided.

3. The Clinical Director review6 the applications for the following:

   a. Completeness.

   b. Appropriateness tO the facility (including whether the applicant has requested privileges which the facility cannot support and whether he/she has not requested privileges which the facility requires).

   c. Accuracy of statements made on applications in comparisonto information obtained from references and other sources.

4. The Clinical Director review6 the application6 and additional information with the credential6 committee, if applicable, and with the Medical Staff Executive Committee, which recommends that the applications to the staff be accepted or rejected and which of the requested clinical privileges should be granted. Finally, the Clinical Director forward6 the Executive Committee's recommendations to the Service Unit Director.

5. The Service Unit Director reviews the applications and the Medical Staff Executive Committee's recommendations, satisfies himself/herself of the appropriateness of the Committee's recommendations, and sends the Committee's recommendations, together with his/her's recommendations to the Service Unit Governing Body.

6. The Service Unit Governing Body, with input from the discipline specific consultant, if applicable, reviews the applications and grants or denies the staff membership and/or clinical privileges to the applicant, and then informs the Medical Staff Executive Committee and the applicant of their decision in writing.

Medica1 Staff Members' and Privileges Renewal:

At intervals specified in the medical staff's bylaws, rules, and regulations, but in no case to exceed two years, all medical staff must renew their medical staff membership and/or clinical privileges. This process will normally be completed by the Clinical Director or the Clinical Director's designee and includes the following steps:

1. The Staff provides to the Clinical **Director**.

   a. Applications to renew his/her membership and clinical privileges, indicating any desired changes in clinical privileges.

   b. Verification of current licensure.

   c. Evidence of continuing professional education obtained outside the facility.

2. medical Director for designee Ensures the performance and documentation of the following tasks:

   a. Reviews the application for completeness.

   b. Reviews the person's service unit file to determine:

      (1) Competency of practice (should be obtainable from records of performance appraisals, Quality Assurance Committee, various other medical staff and hospital committees, peer recommendations, as well as anecdotal information known to the Clinical Director and available from other medical staff members).

      (2) Participation in continuing education activities.

      (3) Participation in medical staff activities.

      (4) Ability and desire to get along with other staff members (medical and support).

      (5) Current physical and mental health status.

   Consider: Have there been any instances of behavior that required disciplinary action or medical or psychiatric intervention since the last time privileges were granted?

   Have those situations been satisfactorily resolved? Are these still issues of concern? Are any problems evident with alcohol or drug abuse?

c. Review the applications and his/her findings with the Medical Staff Executive Committee to arrive at a recommendation concerning renewal of staff membership and clinical privileges, with special attention to any requested or recommended change6 in clinical privileges. The applicant whose renewal is being considered by the Medical Staff Executive Committee Shall not be present during this review.

d. Forward the Committee's recommendations to the Service Unit Director.

3. The Service Unit Director Reviews the applications and recommendations, satisfies himself/herself of the appropriateness of the committee's reccmmendations, then forwards the recommendations, together with his/her recommendations to the Service Unit Governing Body.

4. The Service Unit Governing Body with input from the discipline specific consultant ,if applicable reviews the applications and grants or denies the staff membership and/or clinical privileges to the applicant, and then informs the Medical Staff Executive Committee and the applicant of their decision in writing.

5. The Clinical Director Reviews the Service Unit Governing Body's decision with the staff member.

Note: If an applicant disagrees with the outcome of the foregoing process: Appeals and fair hearing procedure6 are to be followed to resolve the disagreement. These procedures should be addressed in every service unit's medical staff bylaws.

Credentialing and Privilegin Medical Staff Members:

All temporary members of the medical staff must be subjected to the same credentialing and privileging process as members of the other medical staff categories. In most instances, it should be possible to complete the process before the person reports for duty. Occasionally, there may be an emergency situation where there is not enough time to get the applications to the person before the temporary staff member leaves for the service unit.

In these instances, the temporary staff member should:

1. Bring a copy of his or her license to the service unit.

2. Bring a copy of his/her notice of board certification, completion of internship or residency, or other verification of certification or training, as applicable.

3. Bring copies of at least two letters of recommendation.

4. Complete the applications for medical staff membership and clinical privileges immediately upon reporting to the service unit.

5. Bring evidence of medical liability insurance (contract providers Only).

When the Clinical Director learns that there will be an emergency need for a temporary medical staff member, the Clinical Director should notify the Area Physician Recruiter, Chief Medical Officer, or discipline-specific consultant as to whom the replacement is, when he/she is arriving, and how long he/she will be there.

When the staff member arrives, the Clinical Director should:

1. Ensure that the staff and privileges application forms are completed.

2. Review the materials (license, etc.) brought by the temporary medical staff applicant to ensure that they are in order and that the individual has adequate training, experience, competence, and Skills appropriate for the need6 of the particular facility. If letters of recommendation are unavailable, references must be checked via telephone.

3. Begin the credentialing process described earlier in this issuance. The Clinical Director will make recommendations to the Service Unit Director who can grant temporary privileges until the Service Unit Governing Body can convene. These steps must be completed prior to permitting the individual to see patients and provide care in the facility.

When these steps have been completed, the remainder of the process is the same as for all other staff members.

Suggested Forms For Credentials Review Process

Circular Appendix 95-16-B.l

12/08/95

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Expires: 07/31/98

ESTIMATED AVERAGE BURDEN TIME PER RESPONSE

The public reporting burden for completing this information collection is estimated to average 45 minutes. The estimate includes time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to: Reports Clearance Officer, Attention: PRA, United States Public Health Service, Hubert H. Humphrey Building, Room 721-B, 200 Independence Avenue, SW, Washington, D.C. 20201; reference Paperwork Reduction Project (0917-0009). DO NOT SEND COMPLETED FORMS TO THIS ADDRESS.

PLEASE TYPE OR PRINT LEGIBLY

INDIAN HEALTH SERVICE
APPLICATION FOR APPOINTMENT *TO*
THE MEDICAL STAFF OF

PHS Indian _____
(Hospital/Health Center) City State

as a: Physician _____ Dentist _____ Psychologist _____
Optometrist _____ Audiologist _____ Podiatrist _____
Other _____

1. DEMOGRAPHIC INFORMATION:

A. Name in Full: _____

B. Office Address: _____

Telephone (_____)

C. Home Address: _____

Telephone: (_____)

D. Date of Birth: _____ Birthplace: _____

E. Citizenship: _____

2. H E A L T H : Applicant is required to provide evidence of a health status statement signed by a physician stating that the applicant is mentally and physically capable of exercising the clinical privileges requested.

A. Note any significant physical or mental conditions; present or past drug abuse or dependency, or chronic contagious disease that would render the applicant mentally **or** physically incapable of carrying out the required functions of their medical staff role and clinical privileges requested.

_____

_____

B. Last Medical Exam:
Date: _____ Location: _____

C. Examiner:
Name: _____
Address: _____

D. Immunity Status:

Disease	Date of Vaccination/Titer	Titer Result
Rubella	_____	_____
Rubeola	_____	_____

E. Tuberculosis Status:

Date of last PPD: _____

Result: Pos: Neg:

If positive, explain: _____

3. PREPROFESSIONAL EDUCATION: If more than two schools, give information on an attached sheet.

College/University: _____
Address: _____

Dates Attended: _____
Date of Graduation: _____ Degree: _____
Honors: _____

College/University: _____
Address: _____

Dates Attended: _____
Date of Graduation: _____ Degree: _____
Honors: _____

4. PROFESSIONAL EDUCATION: If more than one school, identify and explain on a separate sheet.

College/University: _____
Address: _____

Date of Graduation: _____ Degree: _____
Honors: _____

5. INTERNSHIP: (or other single postgraduate year)

Hospital/Location: _____
Address: _____
Type/Specialty: _____ Dates: _____

6. RESIDENCIES: Fellowships, Preceptorships, Postgraduate Education, Teaching Appointments (most recent first)

1. Hospital/Location: _____
Address: _____
Type/Specialty: _____ Dates: _____

2. Hospital/Location: _____
Address: _____
Type/Specialty: _____ Dates: _____

3. Hospital/Location: _____
Address: _____
Type/Specialty: _____ Dates: _____

7. SPECIALTY:

	CERTIFIED	DATE	RECERTIFIED	DATE
A.	_____	_____	_____	_____
B.	_____	_____	_____	_____

8. PROFESSIONAL LISCENSURE (Certification, registration) (List all jurisdictions in which you currently hold or have ever held a professional license; continue on a separate sheet if more than three):

	STATE	NUMBER	EXPIRATION DATE
A.	_____	_____	_____
B.	_____	_____	_____
C.	_____	_____	_____

9. DRUG ENFORCEMENT NUMBER:

Drug Enforcement Administration (DEA) Number: _____

10. AFFILIATIONS List all present and previous clinical practice affiliations. Include all work experiences at IHS, Tribal, or Urban Indian health care facilities.

A. Individual/Group:

1. Name: _____ Dates: _____
Address: _____
Nature/Position: _____

2. Name: _____ Dates: _____
Address: _____
Nature/Position: _____

B. Hospital/Medical Staff: Include military or other Federal or State-Government services.

1. Name: _____ Dates: _____
Address: _____
Position/Title: _____

2. Name: _____ Dates: _____
Address: _____
Position/Title: _____

3. Name: _____ Dates: _____
Address: _____
Position/Title: _____

11. MEMBERSHIP IN PROFESSIONAL SOCIETIES

A. _____

B. _____

C. _____

12. **PROFESSIONAL REFERENCES:**

The names, mailing addresses, and telephone numbers of at least two (2) individuals are required.

A. Name: _____
Address: _____
Telephone: _____

B. Name: _____
Address: _____
Telephone: _____

C. Name: _____
Address: _____
Telephone:. _____

Note: Written information from two references is required before action can be taken on this application. For those in training, one reference must be from the Director (Chief of Service) of the training program. For other applicants, who are currently members of one or more medical staffs, one letter must be from the Chief of Staff Or Departmental Chairperson from each hospital where the applicant is on the active medical staff. Information will be requested regarding professional judgment, competence, and personal character. References will be evaluated based on the extent of direct work with and clinical observation of the applicant.

13. CONTINUING PROFESSIONAL EDUCATION

Describe topics, sources, and dates of all continuing education you have completed in the last three years and a professional recognition certificate received, if applicable (a summary sheet may be attached).

14. CARDIOPULMONARY RESUSCITATION

Current training and certification in Cardiopulmonary Resuscitation (CPR), basic life support, is highly desirable for all professionals involved in direct patient care. training will be required of some in accordance with medical staff bylaws, particularly of physicians, dentists, and optometrists. ,

A. I have had no CPR Training within the past year. _____

B. I am certified in basic life support? _____
My certification expires on: _____

C. I am certified in advanced cardiac life support? _____
My certification expires on: _____

D. I am certified in advanced trauma life support? _____
My certification expires on: _____

E. I am certified in pediatric advanced life support? _____
My certification expires on: _____

15. LIABILITY INSURANCE:

(List current carrier first and any other carriers for the past 10 years - continue on a separate sheet if necessary)

A. Carrier: _____ Amount of coverage: _____
Agent: _____ Policy No.: _____
Expiration Date: _____

B. Carrier: _____ Amount of coverage: _____
Agent: _____ Policy No.: _____
Expiration Date: _____

16. **LIABILITY CLAIMS AND** ADVERSE ACTION:

If your answer to any of the following is "yes" please provide full details on an attached separate sheet:

A. Have liability claims been filed against you, or against a hospital, other health care entity, corporation, or government, based on a case under your care?
YES: _____ NO: _____

B. Have judgments or settlements been made involving you or against a hospital, corporation, or government based on a case under your care?
YES: _____ NO: _____

c. Have you ever had, or are you about to have, your professional liability insurance declined, canceled, issued on special terms, or refused for renewal?
YES: _____ NO: _____

D. Has your professional license (certification or registration) to practice in any jurisdiction ever been limited, placed in probationary status, restricted, suspended, denied, revoked, voluntarily surrendered, or not renewed?
YES: _____ NO: _____

E. Have you ever been censured or reprimanded by a licensing (certifying, etc.) board, hospital medical staff, professional society, or other professional organization?
YES: _____ NO: _____

F. Have you ever been refused membership on a medical, dental, or other professional staff?
YES: _____ NO: _____

G. Have any or all of your privileges at any health-care facility ever been or are about to be limited, reduced, suspended, revoked, voluntarily surrendered in the course of an investigation, or not renewed? Have you resigned from a medical staff because of concern that your privileges might have been limited, suspended, or revoked? Have any other professional disciplinary actions been taken against you?
YES: _____ NO: _____

H. Has your narcotics registration, Federal or State, ever been denied, limited, suspended, voluntarily surrendered, not renewed, or revoked?
YES: _____ NO: _____

I. Have you ever been denied membership, or renewal thereof, or been subject to disciplinary action in any professional society or organization?
YES: _____ NO: _____

J. Have any civil or criminal charges ever been filed against you or are you under an investigation that might lead to such charges?
YES: _____ NO: _____

K. Have you ever been sanctioned by Medicare or a Medicaid program, or by any other Federal agency?
YES: _____ NO: _____

L. Are you currently involved in or have knowledge of a pending investigation, review, or surveillance of your professional practice or conduct that could result in an adverse action concerning your ability to bill and collect from Medicare or Medicaid programs; your narcotics registration; yourprofessional license registration or certification; or your medical staff membership or privileges?
YES: _____ NO: _____

Explain affirmative responses in detail.

I agree to abide by all lawful standards, policies, and rules of the facility, the Area, the Indian Health Service, the U.S. Public Health Service, and the Department of Health and Human' Services as they apply to my responsibilities and practice as a member of this medical staff. I pledge to maintain an ethical practice and to provide for the continuous care of all my patients. I further agree to immediately disclose to the medical staff and/or governing body more detailed information related to all "yes" responses in Section 16 of this application, if **asked** to do so. In addition, I agree to immediately report to the Clinical Director any new information concerning a "yes" response or concerning **a** response that becomes "yes" after filling out this medical staff application, either while medical staff membership and/or privileges are pending or after they have been granted.

Applicant's Signature: _____ Date: _____

Circular Appendix 95-16-B.1

12/08/ 95

RECOMMENDATIONS AND APPROVALS

1. DISCIPLINE-SPECIFIC SUPERVISOR OR CONSULTANT:
(if a current member of the medical staff)

I do ____ do not ____ recommend appointment to the medical staff

Comments:

_____

_____

Signature: _____ Date: _____

2. EXECUTIVE: (or Credentials & Privileges) Committee

We do ____ do not, recommend appointment to the provisional / active / temporary / courtesy medical staff.

Comments:

_____

_____

Signature: _____ Date: _____

3. CLINICAL DIRECTOR:

I do ____ do not recommend appointment to the provisional / active / temporary / courtesy medical staff.

Comments:

_____

_____

Signature: _____ Date: _____

4. **SERVICE UNIT DIRECTOR:**

I do do not recommend appointment as noted above.

Comments:

Signature: _____ Date: _____

5. **CHAIR, SERVICE UNIT GOVERNING BODY:**

Appointment is is not approved.

Comments:

Signature: _____ Date _____

STATEMENT OF UNDERSTANDING AND RELEASE
(To be signed by all applicants, for initial appointment)

By applying for appointment to the medical staff, I signify my willingness to appear for interviews in regard to my application and authorize Indian Health Service (IHS) representatives to consult with administrators and members of medical staffs of other institutions with which I have been associated and with others (including past and present insurance carriers, State licensure boards, etc;) who may have information bearing on my professional competence, character, and ethical qualifications. I further consent to the release/disclosure to this facility's professional staff and IHS representatives of all personnel, professional, and personal medical records and documents (including alcohol and drug abuse records at other institutions) that may be material to an evaluation of my professional qualifications and competence to carry out the clinical privileges requested, as well as my moral and ethical qualifications for staff membership.

I further consent to the disclosure, by authorized IHS representatives, of records of my professional service with IHS relating to my personal character and professional qualifications and competence to carry out the clinical privileges granted to me by this IHS facility. This information may be disclosed to any subsequent practitioner(s), facility, State or county medical society, or licensing board to whom or to which I may apply for clinical privileges, membership, or licensure. This may include information regarding drug or alcohol abuse or dependency. At such time, completion of the form: "Authorization for Release of Information,@' Form No. HRSA-810, will be requested.

I fully understand that a false answer to any question in this application, or the misrepresentation of information otherwise provided, may constitute cause for denial/revocation of medical staff appointment and/or clinical privileges, and may be punishable by fine or imprisonment (U.S.C., Title 18, Section 1001).

I certify that the statements/documents that I have made/provided in this application are true, complete, and correct to the best of my knowledge and belief and are made in good faith.

I hereby release from liability all representatives of the Federal Government for their acts performed in good faith and without malice in connection with evaluating my credentials and qualifications, and I hereby release from any liability any and all individuals and organizations who provide information to these representatives in good faith and without malice concerning my professional competence, ethics, character, and other qualifications for the medical staff and any applicable clinical privileges.

I agree to abide by the bylaws, rules, and regulations of the medical staff.

_____ _____

SIGNATURE D A T E

PRIVACY ACT NOTICE FOR CREDENTIALS AND PRIVILEGES REVIEW PROCESS FOR THE MEDICAL STAFF (Notice to subject individual)

The Privacy Act of 1974 (5 U.S.C. 552a) requires that a Federal agency provide a notice to each individual from whom it collects information.

1. The authority for collecting the information requested is found in the Indian Self Determination and Education Assistance Act (25 U.S.C. 450), Snyder Act (25 U.S.C. 13), the Indian Health Care Improvement Act (25 U.S.C. 1601 et. seq., and the Transfer Act (42 U.S.C. 2001-2004).

2. The principal purpose for collecting the requested information is to systematically review the credentials of all current members of Indian Health Service (IHS) medical staffs and those of persons applying for positions on IHS medical staffs, either as employees or contractors, regarding membership and the granting of clinical privileges.

   This information is being requested to ensure that members of the IHS medical staff are qualified, competent, and capable of delivering quality health services consistent with those of the medical community at large and that they are granted privileges commensurate with their training and competence and with the ability of the facility to provide adequate support equipment, services, and staff. This responsibility includes the initial review and verification of a provider's credentials for the purposes of determining eligibility for medical staff membership. The applicant's training, prior experience, and current competence, the needs of the IHS medical staff relative to patient load and diagnostic caseload mix, and the ability of the facility to provide adequate support facilities, services, and staff must be considered prior to granting medical staff membership and delineating specific medical staff privileges. This responsibility requires a mechanism whereby the credentials and clinical privileges will be evaluated, reevaluated, and recertified on a recurring and standardized basis.

3. Information contained in the records created for-these purposes will be maintained by IHS staff in a confidential manner. Releases of this information will only be made on a “need-to-know" basis to employees of the Department of Health and Human Services (HHS) in the performance of their official duties and to non-Departmental personnel for the following routine uses:

   Records, in part or total, may be disclosed to:

   A. Authorized organizations to conduct program evaluation studies, sponsored by IHS (e.g., Joint Commission on Accreditation of Healthcare Organizations).

   B. State or local government health profession licensing boards, the National Practitioner Data Bank established under Title IV of P.L. 99-660, the Federation of State Medical Boards and/or similar entities to inform them of current or former IHS medical staff members whose professional health care activity so significantly failed to conform to generally accepted standards of professional medical practice as to raise reasonable concern for the health and safety of members of the general public. This will be done within the guidelines for notice, hearing, and appellate review as delineated in the medical staff bylaws for the IHS facility and/or within other HHS or IHS regulations or policies.

   C. References listed on the IHS medical staff application and associated forms, for the purpose of evaluating your professional qualifications, experience, and suitability.

   D. State or local health professional licensing boards, health professional organizations, the data bank established under Title IV of P.L. 99-660, the Federation of State Medical Boards or similar entities for the purpose of verifying that all claimed background and employment data are valid and all claimed credentials are current and in good standing.

   E. Other agencies of the Federal, State, and local governments as well as organizations in the private sector that you have applied to or will apply to for clinical privileges, membership or licensure for the purpose of documenting your qualifications and competency to provide health services in your health profession based on your professional performance while employed by the IHS.

F. Department of Justice in case of litigation.

G. Federal, State, or local agency charged with enforcing or implementing a statute, rule, regulation, or order when information contained in the record indicates a violation or potential violation of law, whether civil, criminal, or regulatory in nature.

4. Indian Health Service staff will maintain a log of such disclosures. You may review a copy of this log of disclosures or review copies of materials contained in your medical staff credentials and privileges file. To do so, contact the Clinical Director of your facility or the Area Director, if the official file is maintained at the Area office.

5. Information collected through the use of IHS Credentials and Privileges Review forms are contained in System of Records: 09-17-0003, Indian Health Service Medical Staff Credentials and Privileges Records, Office of Health Programs, IHS/HHS.

6. Applicants are advised that failure to provide the information requested, including Social Security Number, will result in a denial to receive, or to continue to receive, funding as an IHS medical staff member (direct or contract).

TO BE COMPLETED, BY CLINICAL, DIRECTOR OR DESIGNEE

INDIAN HEALTH SERVICE
VERIFICATION OF APPLICATION FOR APPOINT&NT TO THE MEDICAI, STAFF-AND EVALUATION OF REQUEST FOR CLINICAL PRIVILEGES.

This form is provided to facilitate the process of validation of credentialing information provided by applicants in the Application for Appointment to the Medical Staff, to provide a concise record of the steps taken, and to verify the completion of all steps in the validation process. Use of this form is not required; however, THE CLINICAL DIRECTOR MUST SIGN CERTIFICATION TO INDICATE THAT INFORMATION PROVIDED BY APPLICANT HAS BEEN VALIDATED.

(Item number references the item number on the Application for Appointment to the Medical Staff form, Appendix B.l)

ITEM NO.	APPLICATION INFORMATION DESCRIPTION	VERIFIED BY (INITIALS	DATE VERIFIED
4.	Professional Education	_____	_____
5.	Internship	_____	_____
6.	Residencies	_____	_____
	Facility(ies) contacted	_____	_____

Comments: _____

_____

_____

7. Boards: _____ _____

Indicate how validated: _____

Comments: _____

_____

_____

ITEM NO.	APPLICATION INFORMATION DESCRIPTION	VERIFIED BY (INITIALS)	DATE VERIFIED

8. Licensure(s):

	State	How Validated		
A.				
B.				
C.				

Comments: (note any limitations or restrictions)

9. National Practitioner Data Bank Query _____ _____

Comments:

	VERIFIED BY INITIALS	DATE VERIFIED

10. Affiliations:

A. Individuals/Group:

(1) Name: _____ _____ _____

Comments:

(2) Name: _____ _____ _____

Comments:

B. Hospital/Medical Staff:

1. Name:

Position/title confirmed? YES:- NO:-
Privileges modified or reduced? YES:- NO:-
Disciplinary action? YES:- NO:-
Adverse actions? YES:- NO:-
Comments:

2. Name: _____ _____ _____

Position/title confirmed? YES:- NO:-
Privileges modified or reduced? YES:- NO:-
Disciplinary action? YES:- NO:-
Adverse actions? YES:- NO:-
Comments:

3. Name: _____

Position/title confirmed? YES:- NO:-
Privileges modified or reduced? YES:- NO:-
Disciplinary action? YES:- NO:-
Adverse actions? YES:- NO:-
Comments:

	VERIFIED BY INITIALS	DATE VERIFIED
12. Written References (2)	On File	
A.		
B.		
C.		

Note any negative comments:

	VERIFIED INITIALS	BY	DATE VERIFIED

15. Liability Insurance:

Insurance in force? YES N O _____ _____

Carrier: _____

Coverage: _____

16. Liability Claims and Adverse Action: Comments regarding validation of all "yes" answers concerning liability claims and adverse action:

_____

_____

_____

Monitoring/Supervision is recommended:

Privileges requested are consistent with training and experience confirmed in the verification process:

Yes: _____ No: _____

If yes, indicate:

Type: _____
Duration: _____
By Whom: _____

Comments:

_____

_____

Information presented to Executive Committee of the Medical Staff:

Yes: _____ No: _____

Comments of Executive Committee of the Medical Staff:

_____

_____

Circular Appendix 95-160B.2

12/08/95

Recommendation of Executive Committee of the Medical Staff

A. _____ Membership with privileges as requested.

B. _____ Membership with privileges modified as noted.

c. _____ Nonmembership

State reason(s) for nonmembership: _____

CERTIFICATION

I certify that the information provided by the applicant has been validated and, to the best of my knowledge, is correct.

_____ Date

_____ Clinical Director

Circular Appendix 95-16-B.3

12/08/95

OMB No: *0913-0009*
Expires: **07/31/98**

ESTIMATED AVERAGE BURDEN TIME PER RESPONSE

The public reporting burden for completing this information collection is estimated to average 10 minutes. The estimate includes time for reviewing instructions, searching existing data *sources,* gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to: Reports Clearance Officer, Attention: PRA, United States Public Health *Service,* Hubert H. Humphrey Building, Room 721-B, 200 Independence Avenue, SW, Washington, D.C. 20201; reference Paperwork Reduction Project (0917-0009). DO NOT SEND COMPLETED FORM AS TO THIS ADDRESS.

SUGGESTED FORMAT, FOR LETTER TO BE SENT TO REFERENCES OF APPLICANTS OR FOR TELEPHONE SOLICITATION *OF* REFERENCES

Date

Name
Address

Dear Dr./Mr./MS. _____

Dr./Mr./MS. _____ has applied for membership to the medical staff of the Indian Health Service hospital/clinic in _____(location)_____.

We are in the process of validating information contained in his/her application and are asking, that you provide us with your assessment of Dr./Mr./MS. _____ in regards to his/her professional judgment, competence, and personal character. Also, please note the extent to which you have worked with the applicant and/or observed his/her clinical performance. A check sheet has been enclosed with this letter to facilitate your evaluation. Some or all of the information you give us could in the future be released to a State licensing board or similar entity, to other agencies of the Federal Government, or for legal purposes. Your response is voluntary; however, we hope that you will provide this information to us so that we can process Dr./Mr./MS. _____'s application with the most accurate information possible.

Sincerely,

Clinical Director

ARE YOU AWARE OF ANY SUBSTANCE ABUSE/DEPENDENCY PROBLEMS, CURRENT OR PAST?

_____
_____
_____

TO YOUR KNOWLEDGE, DOES THIS APPLICANT HAVE ANY MEDICAL MALPRACTICE SUITS PENDING? Yes: ____ No: ____

A BRIEF DESCRIPTION OF THIS APPLICANT'S STRENGTHS/WEAKNESSES:

_____
_____
_____
_____

SIGNED: _____ TITLE: _____

PRINT: _____

Circular Appendix 95-16-B.3

12/08/95

IHS MEDICAL STAFF PROFESSIONAL REFERENCE CHECKLIST

APPLICANT'S NAME: _____ DATE: _____

APPLICANT'S POSITION: _____

AFFILIATION DATES: _____

THIS REFERENCE IS BASED ON:

DIRECT OBSERVATION:
frequent : -
occasional: -
infrequent: -

INDIRECT **OBSERVATION:**
frequent : ____
occasional: ____
infrequent: ____

DISCUSSION WITH OTHERS WHO 'HAVE DIRECT **KNOWLEDGE:** ____

RECORDS ONLY: ____

EVALUATION OF APPLICANT:

Knowledge/Skills	Excellent	Very Good	**Average**	**Below Aver(*)**	**Unable to Assess(*)**
DIAGNOSTIC ABILITIES	[ ]	[ ]	[ ]	[ ]	[ ]
CLINICAL SKILLS	[ ]	[ ]	[ ]	[ ]	[ ]
SURGICAL SKILLS	[ ]	[ ]	[ ]	[ ]	[ ]
FUND OF KNOWLEDGE	[ ]	[ ]	[ ]	[ ]	[ ]
PATIENT RAPPORT	[ ]	[ ]	[ ]	[ ]	[ ]
PEER RAPPORT	[ ]	[ ]	[ ]	[ ]	[ ]
MAINTENANCE OF MEDICAL RECORDS	[ ]	[ ]	[ ]	[ ]	[ ]
STAFF MEETING PARTICIPATION	[ ]	[ ]	[ ]	[ ]	[ ]
COMPLIANCE WITH MEDICAL STAFF BYLAWS/ RULES & REGULATIONS	[ ]	[ ]	[ ]	[ ]	[ ]
PRODUCTIVITY	[ ]	[ ]	[ ]	[ ]	[ ]
MOTIVATION	[ ]	[ ]	[ ]	[ ]	[ ]
INTEGRITY/ETHICS	[ ]	[ ]	[ ]	[ ]	[ ]
HEALTH STATUS	[ ]	[ ]	[ ]	[ ]	[ ]

(*) Please explain:

_____

_____

_____

Circular Appendix 95-16-B.4

12/08/95

No: 0917-0009
Expires: 07/31/98

ESTIMATED AVERAGE BURDEN TIME PER RESPONSE,

The public reporting burden for completing this information collection is estimated to average 60 minutes. The estimate includes time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to: Reports Clearance Officer, Attention: PRA, United States Public Health Service, Hubert H. Humphrey Building, Room 721-B, 200 Independence Avenue, SW, Washington, D.C. 20201; reference Paperwork Reduction Project (0917-0009). DO NOT SEND **COMPLETE**D FORMS TO THIS ADDRESS

REQUEST FOR REAPPOINTMENT TO THE MEDICAL STAFF

I hereby request reappointment to the medical staff of:

_____ _____ _____
(Hospital/Health Center! (Town/City) (State)

I request that my clinical privileges be:

_____ Renewed as presently granted.
_____ Increased as designated in a memorandum attached hereto.
_____ Reduced as designated in a memorandum attached hereto.

Continuing Professional Education:

Describe topics, sources, and dates of all continuing education you have completed in the past year.

Current CPR, ACLS, ATLS, PALS training status:

1. Certified in basic life support? _____
   Certification expires _____

2. Certified in advanced cardiac life support? _____
   Certification expires _____

3. Certified in advanced trauma life support? _____
   Certification expires _____

4. Certified in pediatric advanced life support? _____
   Certification expires _____

Liability Claims and Adverse Action: If your answer to any of the following is "yes" please provide full details on an attached separate sheet if this information has not previously been submitted to this medical staff:

1. Have there been any previously successful or any currently pending challenges to any of your licenses or registrations (State or district, Drug Enforcement Administration) or the voluntary relinquishment of licenses or registrations?
   YES: ____ NO: ____

2. Has your medical staff membership at another hospital been voluntarily or involuntarily terminated? Have your clinical privileges at another hospital been voluntarily or involuntarily limited, reduced, or lost?
   YES: ____ NO: ____

3. Are you currently or have you been involved in any professional liability actions?
   YES: ____ NO: ____

_____ _____

Signature Date

After review of the applicant's performance, in accordance with the medical staff bylaws and as summarized in the IHS Work Sheet for Reappointmentto the Medical Staff, I do ___do not - recommend reappointment to the_____ medical staff.

I d o do not recommend renewal of clinical privileges as requested above

_____ _____

Clinical Director Date

Comments:

_____

_____

_____

_____

I d o do n o t recommend reappointment and privileges as noted above.

_____ _____

Service Unit Director Date

Comments:

_____

_____

_____

_____

Reappointment and privileges are a r e n o t approved.

_____ _____

Chair of the Governing Body Date

Circular Appendix 95-16-B.5

12/08/95

TO BE COMPLETED BY CLINICAL DIRECTOR OR DESIGNEE

WORK SHEET FORREAPPOINTMENT
TO THE MEDICAL STAFF OF

_____, _____ _____
(Hospital/Health Center; (Town/City) (State)

Name of Applicant: _____

* Any "no" answer on items l-14 and any "yes" answers on items 15-23 need to be explained fully on attached page(s).

	Description	YES	No
1.	Is this applicant physically, mentally, and emotionally capable of ,performing the services required of a member of the medical staff and requested privileges?	____	____
2.	Has this applicant consistently complied with the medical staff bylaws, rules, and regulations of this facility?	____	____
3.	Has this applicant provided verification of current licensure?	____	____
4.	Have favorable reports been received on this applicant's professional competence, clinical judgment, and personal character?	____	____
5.	Are the privileges being sought the same as those currently granted?	____	____
6.	Does this applicant relate and work well with other patient care staff?	____	____
7.	Is this applicant readily available and responsive when needed?	____	____
8.	Does this applicant regularly attend medical staff meetings?	____	____
9.	Has this applicant shown willingness to serve on, or chair, appropriate committees when asked to do so?	____	____

Description	YES	NO
10. When appointed to a committee, has this applicant served in the capacity to which appointed and attended meetings with appropriate regularity?	____	____
11. Has this applicant willingly participated in the quality assurance program and functions of this IHS facility?	____	____
12. Has this applicant been cooperative in observance of medical staff and hospital procedural rules?	____	____
13. Has this applicant been cooperative in compliance with established medical records requirements?	____	____
14. Has this applicant consistently completed medical records within prescribed time limits?	____	____
15. Have any adverse actions been initiated or any judgments rendered against this applicant or against the Federal Government on the basis of this applicant's patient care practices?	____	____
16. Has this applicant required counseling due to non-conformance with standards in his/her clinical practice or medical staff related activities?	____	____
17. Has any disciplinary action been taken against this applicant?	____	____
18. Has this applicant exercised any clinical privileges which had not been granted?	____	____
19. Has there been any reduction or revocation of clinical privileges for this applicant?	____	____
20. Has there been any change in the physical, mental, or emotional health or condition in this applicant?	____	
21. Has this applicant shown evidence of any alcohol or drug abuse or dependency?	____	

Description	YES	NO
22. Has this applicant had any treatment for alcohol or drug abuse or dependency?	____	____
23. Did the National Practitioner Data Bank query reveal any adverse information?	____	____

24. Relative to the review functions listed, how does this applicant's performance as a member of the patient care staff compare to the staff as a whole in numbers of problems attributed to his/her patient care practices?

	Fewer than Average	More than Average	Average	Does Not Apply
a. Monitoring Functions				
b. Surgical Case Review				
c. Pharmacy/Therapeutics Review				
d. Medical Records Review				
e. Blood Usage Review				
f. Antibiotic Usage Review				
g. Morbidity/Mortality Review				
h. Emergency Care Review				
Infection Control				
i: Utilization Review				
k. Incidence Reports				
1. QA Committee Reports				

Quantitate and comment on any "more than average" ratings:

25. Information presented to the Medical Staff Executive Committee?

Y E S : N O : **Date:** _____

26. Comments of Medical Staff Executive Committee:

27. Recommendation of the Medical Staff Executive Committee:

a. _____ Continue membership with privileges as requested, including requested modifications, if any.

b. _____ Continue membership with same privileges as previously granted. 'Changes requested by applicant denied.

c. _____ Continue membership with privileges modified as recommended by the Medical Staff Executive Committee. (Attach these recommendations.)

d. _____ Discontinue membership.

CERTIFICATION

I certify that the information provided herein is true and correct to the best of my knowledge.

Clinical Director _____ Date _____

SUGGESTED MEDICAL PRIVILEGES REQUEST FORMS

Section	Type of Medical Privileges Form
c.1	Introduction
c.2	Medical Privileges request form
C.2a	Medical Privileges request form (categorical method for OB-GYN privileges)
c.3	Surgical Privileges request form (for general surgery and surgical specialties)
c.4	Psychiatric Privileges request form
c.5	Anesthesia Privileges request form
C.6	Dental Privileges request form
c.7	Optometric Privileges request form
C.8	Psychology Privileges request form
c.9	Audiologic Privileges request form
c. 10	Podiatric Privileges request form
c.11	Radiology Privileges request form
c.12	Pathology Privileges request form

INTRODUCTION

GENERAL INFORMATION REGARDING PRIVILEGES REQUEST FORMS:

The granting of clinical privileges must be very individualized to both the individual clinician and to the facility where the privileges will be performed. For this reason a standardized privileges form is not desirable. The two methods most commonly utilized are the explicit listing of every privilege desired (generally referred to as the "laundry list") or to group privileges requested by category (see appendix C.2.a).

In Appendix C, parts 2-9 are a collection of explicit privileges request forms. Please note that the "Medical Privileges Request Form" (C.2) is designed more for the generalists performing some functions within the specialty areas noted. Appendix C.3 is a request form for general and specialty surgical procedures for physicians in those respective surgical fields. Facilities need to prepare their own privileges lists, commensurate with the ability of that individual facility to support certain procedures or types of medical care.

No: 0917-0009
Expires: 07/31/98

ESTIMATED AVERAGE BURDEN TIME PER RESPONSE

The public reporting burden for completing this information collection is estimated to average 60 minutes. The estimate includes time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to: Reports Clearance Officer, Attention: PRA, United States Public Health Service, Hubert H. Humphrey Building, Room 721-B, 200 Independence Avenue, SW, Washington, D.C. 20201; reference Paperwork Reduction Project (0917-0009). DO NOT SEND COMPLETED FORMS TO THIS ADDRESS.

SAMPLE

INDIAN HEALTH SERVICE
MEDICAL PRIVILEGES REQUEST FORM

INTRODUCTION: This Medical Privileges request form must be accompanied or preceded by a completed application for medical staff appointment, including the necessary supporting documents. Many clinical privileges pertinent to the practice of medicine and surgery are listed below. This list contains both outpatient and inpatient items. The request for privileges must reflect both the applicant's and the facility/staff's ability to carry out or support the various functions. This list is intended primarily for the generalist physician or physician extender performing these functions within the areas listed. Internists, pediatricians, and obstetricians may request additional appropriate privileges commensurate with their expertise within their specialty and the facility's ability to support the requested privileges. They should be presented in an attached list and referenced on this form under "other."

INSTRUCTIONS FOR COMPLETING THE FORM

APPLICANT: With a check mark in the appropriate location, indicate for each item your decision to request either LIMITED or FULL privileges. LIMITED means that the applicant may function in the area of the stated clinical privileges only under the direct supervision of a provider holding FULL privileges. "Direct Supervision" may be fulfilled via telephone consultation, if appropriate. FULL means that the applicant is entitled to function independently, following standards consistent with the medical community at large. Be sure to sign the request as indicated on page 13.

DISCIPLINE SPECIFIC SUPERVISOR OR CONSULTANT: Indicate your recommendation for each requested clinical privilege by placing a check mark in the appropriate location for either FULL, LIMITED, or NOT RECOMMENDED (NR). Please explain any recommended limitations or denial of privileges on an attached sheet. Your recommendations are considered by the Governing Body when granting or not granting privileges.

MEDICAL PRIVILEGES REQUEST FORM

	Applicant Requests Ltd	Full	Supervisor/ Consultant Recommend& NR	Ltd	Full
1. OBSTETRICS: (See Appendix C.2.a)					
A. Minor:					
1. Normal prenatal/postpartum care	-	-		-	-
2. Normal spontaneous labor and vaginal delivery	-		-	-	
3. Midline episiotomy and repair	-	-	-		
4. Local and pudendal anesthesia	-	-		-	
5. Repair of vaginal & cervical laceration -	-		-	-	
6. Management of mild preeclampsia	-		-		
7. Amniotomy	-				-
8. Management of postpartum hemorrhage	-		-	-	
9. Management of postpartum infection	-				
10. Interpretation of external and internal fetal heart rate monitor tracings	-			-	
11. Manual removal of placenta	-	-			
12. Postpartum uterine exploration and/or curettage	-		-		
13. Low forceps delivery	-		-		
14. Curettage for incomplete abortion	-	-		-	-
15. Other (Specify): _____	-		-	-	
B. Major:					
1. Multiple pregnancy	-		-	-	
2. Amniocentesis	-		-		
3. Breech delivery	-	-			-
4. Paracervical block	-	-		-	-
5. Induction/stimulation of labor	-		-	-	-
6. Cesarean section	-		-	-	
7. Mid forceps delivery			-		
8. Management of medical complications in pregnancy i.e., diabetes, renal disease, severe preeclampsia,					

	Applicant Requests Ltd	Full	Supervisor/ Consultant Recommends NR	Ltd	Full
9. OB ultrasound	-	-	-	-	-
10. Other (Specify): _____	-	-	-	-	-

Note: All clinicians granted minor or major obstetric privileges must also be qualified for and granted privileges in newborn resuscitation and stabilization.

II. GYNECOLOGY: (see Appendix C.2.a)

A. Minor:

1. I & D of vulvar or perineal abscess		-	-	-	-
2. Biopsy of perineum, vulva, cervix, vagina	-	-			
3. Endometrial biopsy	-				
4. Insertion/removal of intrauterine device		-			
5. Dilatation and curettage	-	-	-	-	-
6. Culdocentesis	-	-	-	-	-
7. Polypectomy	-		-	-	-
8. Vaginal or uterine packing		-	-	-	-
9. Other (Specify): _____	-	-	-	-	-

B. Major:

1. Pelvic exam under anesthesia	-	-	-	-	-
2. Tubal ligation	-	-	-	-	-
3. Marsupialization of Bartholin's cyst	-	-	-	-	-
4. Abdominal hysterectomy	-	-	-	-	-
5. Incidental appendectomy	-	-	-	-	-
6. Vaginal hysterectomy		-	-	-	-
7. A & P repair	-	-	-	-	-
8. Peritoneoscopy (laparoscopy)	-	-	-	-	-
9. Salpingoophorectomy	-	-	-	-	-
10. Other (Specify): _____		-	-	-	-

III. PEDIATRICS:

	Applicant Requests Ltd	Applicant Requests Full	Supervisor/ Consultant Recommends NR	Supervisor/ Consultant Recommends Ltd	Supervisor/ Consultant Recommends Full
A. Hepatic and Gastrointestinal Disease:					
1. Hepatitis	-	-			-
2. Peptic ulcer disease	-	-		-	-
3. Diarrheas	-	-		-	
4. Other (Specify): _____	-	-	-	-	
B. Renal Disease Hypertension:					
1. Acute or chronic glomerulonephritis		-	-		-
2. Nephrotic syndrome		-			-
3. Hypertension	-	-	-		
4. Chronic renal failure	-	-	-		
5. Other (Specify): _____	-		-		
C. **Pulmonary Disease:**					
1. Uncomplicated asthma	-	-	-	-	-
2. Complicated asthma	-	-	-	-	-
3. Ventilatory management		-	-	-	-
4. Pneumonia		-	-	-	-
5. Cystic fibrosis		-	-	-	-
6. Other (Specify): _____		-	-	-	-
D. Cardiac Disease:					
1. Nonsurgical congenital heart disease		-		-	
2. Rheumatic heart disease		-		-	
3. Heart failure, acute and/or chronic		-	-		
4. Cardiac arrhythmias		-	-		
5. Other (Specify): _____		-			
E. **Metabolic and Endocrine Disease:**					
1. Fluid and electrolyte problems		-	-		
2. Diabetes mellitus		-	-		
3. Disease of the thyroid gland		-			-
4. Menstrual disorders	-	-		-	-
5. Growth disorders	-	-		-	-
6. Other (Specify):	-			-	

	Applicant Requests		Supervisor/ Consultant Recommends		
	Lta	Full	NR	Ltd	Full.
F. Rheumatologic Disease.					
1. Lupus erythematosus	-	-	-	-	-
2. Juvenile rheumatoid arthritis	-	-	-	-	-
3. Other (Specify): _____	-	-	-	-	-
G. Infectious Disease;					
1. Septic arthritis	-	-	-	-	-
2. Osteomyelitis	-	-	-	-	-
3. Urinary tract infection	-	-	-	-	-
4. Tuberculosis	-	-	-	-	-
5. CNS infections	-	-	-	-	-
6. Neonatal sepsis	-	-	-	-	-
7. Other (Specify): _____	-	-	-	-	-
H. Hematologic and Oncologic Disease;					
1. Anemias	-	L	-	-	-
2. Coagulation disorders	-	-	-	-	-
3. Thrombocytopenia	-	-	-	-	-
4. Cancer chemotherapeutic drug admin	-	-	-	-	-
5. Cancer patient management	-	-	-	-	-
6. Transfusion	-	-	-	-	-
7. Erythroblastosis	-	-	-	-	-
8. Exchange transfusion	-	-	-	-	-
9. Other (Specify): _____	-	-	-	-	-
I. Newborn Nursery Care:					
1. Care of normal infant	-	-	-	-	-
2. Care of premature infant	-	-	-	-	-
3. Hemolytic disease of newborn	-	-	-	-	-
4. Respiratory distress syndrome	-	-	-	-	-
5. Neonatal resuscitation/emergency stabilization	-	-	-	-	-
6. Other (Specify): _____	-	-	-	-	-

	Applicant Requests		Supervisor/ Consultant Recommends		
	Lta	Full	NR	Ltd	Full
J. Other, Pediatrics:					
1. Failure to thrive	-	-	-		
2. Adolescent gynecology	-	-	-		
3. Well child care	-	-	-	-	
4. Convulsive disorders	-	-	-	-	
5. Fever of unknown origin	-	-	-		-
6. Other (Specify): _____	-	-	-	-	-
IV. MEDICINE:					
A. Hepatic and Gastrointestinal Disease:					
1. Cirrhosis	-	-	-		
2. Decompensated cirrhosis	-	-	-		
3. Hepatitis	-	-	-		-
4. Cholecystitis	-	-	-	-	-
5. Pancreatitis	-	-	-	-	-
6. Regional enteritis	-	-	-		
7. Ulcerative colitis	-	-	-		-
8. Peptic ulcer disease	-	-	-	-	-
9. Acute G.I. bleeding	-	-	-	-	-
lO. Other (Specify): _____	-	-	-	-	
B. Renal Disease:					
1. Glomerulonephritis	-	-	-	-	
2. Pyelonephritis	-	-	-		-
3. Nephrosis		-		-	-
4. Acute insufficiency-conservative	-	-	-	-	
5. Chronic insufficiency	-	-	-		
6. Other (Specify): _____	-	-			
c. Pulmonary Disaase:					
1. Uncomplicated pneumonia	-	-			-
2. Complicated pneumonia		-		-	-
3. Emphysema and chronic bronchitis	z	-			-
4. Pulmonary insufficiency	-	-		-	-
5. Pulmonary embolus	-	-	-	-	-
6. Pneumothorax	-	-	-	-	-
7. Ventilator management	-	-	-		
8. Oxygen therapy	-	-			-
9. Asthma	-	-			-
lO. Other (Specify): _____	-				-

	Applicant Requests		Supervisor/ Consultant Recommends		
	Ltd	Full	NR	Ltd	Full
D. Cardiac Disease:					
1. Electrocardiographic interpretation		-	-	-	
2. congestive heart failure, acute		-	-	-	
3. Congestive heart failure, chronic		-		-	
4. Ischemic heartdisease, angina	-	-	-	-	
5. Myocardial infarction, uncomplicated	-	-	-		
6. Myocardial infarction, complicated	-	-			
7. Valvular heart disease	-	-	-		
8. Pericarditis	-	-	-		
9. Cardiac arrhythmias		-		-	
10. Cardioversion-medical	-	-	-	-	
11. Cardioversion-electrical	-	-	-	-	
12. Thrombophlebitis	-	-	-		
13. Other (Specify): _____		-	-	-	
E. Hypertension:					
1. Essential hypertension		-	-	-	
2. Malignant hypertension	-	-	-	-	
3. Other (Specify): _____	-	-	-	-	
F. Metabolic and Endocrine Disease:					
1. Diabetes Mellitus	-	-	-		
2. Diabetes Mellitus, complicated by keto-acidosis or coma	-	-	-	-	
3. Hypo/hyperthyroidism, uncomplicated	-	-	-	-	
4. Hypo/hyperthyroidism, severe/complicated	-	-	-	-	
5. Gout	-	-	-	-	
6. Other (Specify): _____	-	-	-	-	
G. Collagen Diseases:					
1. Lupus erythematosus	-	-	-	-	
2. Scleroderma	-	-	-	-	
3. Other (Specify): _____	-	-	-		

	Applicant Requests Ltd	Applicant Requests Full	Supervisor/ Consuitant Recommends NR	Supervisor/ Consuitant Recommends Ltd	Supervisor/ Consuitant Recommends Full
H Arthritis:					
1. Rheumatoid arthritis		-			-
2. Osteoarthritis	-	-		-	-
3. Other (Specify): _____	-		-	-	-
I. Hematologic. Oncologic Disease;					
i. Anemias	-		-	-	-
2. Thrombocytopenias			-		-
3. Cancer chemotherapeutic drug administration	-			-	-
4. Cancer patient management	-		-	-	-
5. Other (Specify): _____	-	-	-	-	-
j. Nuerological Diseases					
1. Cerebrovascular accident	-		-	-	-
2. Convulsive disorders		-	-	-	-
3. Parkinsonism		-			-
4. Degenerative neurological disorders			-	-	-
5. Meningitis			-	-	-
6. Other (Specify): _____		-			-
K. Allergy (Medical or Pediatric):					
1. Desensitization		-			-
2. Urticaria		-			-
3. Other (Specify): _____	-			-	-

v. SURGICAL OR PROCEDURAL : (See Appendix C.3)

	Applicant Requests Ltd	Full	Supervisor/ Consultant Recommends NR	Ltd	Full
A. Skin:					
1. I & D of abscess	-	-	-		
2. Wound debridement	-	-			-
3. Incisional and excisional biopsy	-	-		-	-
4. Excision of benign tumors	-	-	-	-	-
5. Repair & closure of simple lacerations (not involving tendons/nerves/major vessels)					-
6. Repair & closure of complicated lacerations				-	-
7. Electra-surgical destruction of lesions (Fulguration)					-
8. Pilonidal cyst drainage				-	-
9. Lymph node biopsy			-	-	-
10. First and second degree burns			-		-
11. Other (Specify): _____	-				-
B. Ophthalmologic:					
1. I & D abscess of lid	-				
2. Removal of superficial foreign bodies	-		-	-	
3. Cornea1 abrasion		-	-	-	
4. Other (Specify): _____	-	-			
C. ENT and Plastic Surgery:					
1. Tracheostomy	-	-	-		-
2. I 6 D abscess/hematoma of canal/auricle	-		-		
3. Foreign body removal from nose or ear		-			
4. Laryngoscopy	-	-			-
5. Nasal packing	-		-	-	-
6. Nasal fracture reduction			-	-	-
7. Blepharoplasty			-	-	
8. Myringotomy		-	-		
9. Other (Specify): _____	-	-			

	Applicant Requests Lta	Full	Supervisor/ Consultant Recommends NR	Ltd	Full
D. Digestive System:					
1. I & D perirectal abscesses	-	—	-	-	-
2. Electrocautery/excision of anal condylomata	-	—	-	-	-
3. I & D oral abscesses	-	—	-	-	-
4. Biopsy mouth, tongue or lip lesions	-	—	-	-	-
5. Repair oral lacerations	-	—	-	-	-
6. Passage & use of Sengstaken-Blakemore tube	-	-	-	-	-
7. Gastric lavage	-	-	-	-	-
8. Liver biopsy, closed	-	-	-	-	-
9. Proctosigmoidoscopy, anoscopy	-	-	-	-	-
10. Proctosigmoidoscopy; anoscopy, w/ biopsy	-	-	-	-	-
11. Diagnostic paracentesis	-	-	-	-	-
12. Therapeutic or decompressive paracentesis	-	-	-	-	-
23. Closed reduction of hernias	-	-	-	-	-
14. GastroscoDv	-	-	-	-	-
15. other (Specify):	-	-	-	-	-
	-	-	-	-	-
E. Orthopdic:					
1. Muscle biopsy	-	-			
2. Injection of tendon sheath, ligament trigger points, or bursae	-	-	-	-	-
3. Arthrocentesis	-	-	-	-	-
4. Bone marrow aspiration	—	-	-	-	-
5. Bone marrow biopsy	—	-	-	-	-
6. closed reduction of simple fractures of phalanges, clavicles, ribs, toes	—	-	-	-	-
7. Closed reduction of simple fractures of radii ulnae, humeri, tibiae, fibulae (Circle which applying for)	—	-	-	-	-
8. Reduction of dislocations of hip, elbows, shoulders fingers	—	-	-	-	-
9. Application of casts and splint	—	-	—	—	—
10. Non-surgical &non-neurological traction	—	-4-	—	—	—
11. Other (Specify): _____	-	-	—	—	—
	-	-	—	—	—

	Applicant Requests Ltd	Applicant Requests Full	Supervisor/ Consultant Recommends NR	Supervisor/ Consultant Recommends Ltd	Supervisor/ Consultant Recommends Full
F. Thoracic :					
1. Thoracentesis	-	-			-
2. Tube thoracostomy	-	-			-
3. Pleural biopsy -	-	-		-	-
4. Bronchoscopy	—		-	-	-
5. Other (Specify): _____	—	-	-	-	
G. **Genito-urinary, Renal, Urologic**:					
1. Hemodialysis		-	-	-	
2. Peritoneal dialysis		-			
3. Bladder aspiration by needle or catheter	-	-		-	
4. Vasectomy	-	-	-	-	
5. Circumcision		-	-	-	
6. Meatotomy		-	-		-
7. Bladder irrigation	-	-		-	-
8. Other (Specify): _____	-	-		-	-
H. **Neurological**:					
1. Peripheral nerve block	-	-		-	-
2. Lumbar puncture	-	-		-	-
3. Local/regional anesthesia administration	-	-			-
4. observe for head injury	-	-		-	-
5. Subdural Tap	-	-	-	-	
6. Other (Specify): _____	-	-	-		
I. Vascular					
1. Arterial puncture	-	-	-	-	-
2. Insertion and monitoring of CVP line	-	-	-	-	-
3. Insertion of temporary cardiac pacemaker		-	-	-	-
4. Cutdown for insertion of catheters	-	—	—	—	—
5. Umbilical vein catheterization	-	—	—	—	—
6. Umbilical artery catheterization	-	—	—	—	—
7. Right heart catheterization	-	—	—	—	—
8. Other (Specify): _____		—	—	—	—

	Applicant Requests Ltd	Full	Supervisor/ Consultant Recommends NR	Ltd	Full
J. Emergency Procedures Not Covered Elsewhere:					
1. Cricothyroidotomy					
2. Endotracheal intubation					
3. Insertion of oropharyngeal airway					
4. Intracardiac injection					
5. Pericardiocentesis					
6. Peritoneal lavage					
7. Use of manual and mechanical resuscitator					
8. Use of rotating tourniquets					
9. Use of MAST trousers					
10. Acute drug overdoses					
11. Other (Specify): _____					
VI. PSYCHIATRIC (See Appendix C.4)					
A. Anxiety disorders					
B. Depression					
c. Chronic schizophrenia					
D. Substance abuse					
E. Hyperactivity in children					
F. Other (Specify): _____					
V I I . RADIOLOGY See Appendix C.ll)					
A. Radiograph interpretation (with report)					
B. Ultrasound interpretation (with report)					
C. Injection of, contrast material (venous, arterial, lymphatic)					
D. Performance of x-rays:					
1. Chest					
2. Extremities					
3. Others					
E. Other (Specify): _____					

Circular Appendix 95-16-C.2

12/08/95

MEDICAL PRIVILEGES REQUEST FORM

1. I hereby request, the clinical privileges as indicated on the forms attached.

_____ _____
Applicant Date

2. I hereby recommend the clinical privileges as indicated.

_____ _____
Supervisor/Consultant Date

3. As Chairperson of the Medical Staff Executive Committee, I hereby recommend the clinical privileges: (check one)

___ As noted.
___ With the following exceptions, deletions, additions, or conditions:

_____ _____
Clinical Director Date

4. I hereby recommend the applicant for clinical privileges.

_____ _____
Service Unit Director Date

5. Privileges are hereby granted: (Check one)

___ As noted.
___ With the following exceptions, deletions, additions, or conditions:

_____ _____
Chairperson of the Governing Body Date

MEDICAL PRIVILEGES REQUEST FORM
(CATEGORICAL METHOD FOR OB-GYN PRIVILEGES)

I. OBSTETRICS:

	Applicant Requests		Supervisor/ Consultant Recommends		
	Ltd	Full	NR	Ltd	Full
A. Category I:					
1. Diagnosis & therapy, with minimal threat to life	-	-	-	-	-

Qualifications:

Physicians with minimal formal training in the specialty, but with training and experience in the care of the specific conditions, and Certified Nurse Midwives. In either case, clinician has had at least 30 supervised deliveries.

Examples:

1. Normal prenatal and postpartum care	-	—	—	—	
2. Uncomplicated labor and vaginal delivery	-	-	-	w	-
3. Maternal-fetal monitoring (clinical and electronic)			-	-	-
4. Local and pudendal anesthesia	-	-	-	-	-
5. Amniotomy		-	-	s	-
6. Episiotomy and repair of second degree laceration	-		-	-	-
7. Use of oxytocic drugs after completion of third stage	-		-	-	-
8. Management of uncomplicated postpartum infection	-		-	v	-
9. Repair of minor vaginal/cervical laceration	-		-	-	-
10. Management of mild preeclampsia after consultation with an OB/GYN specialist	-		-	-	-
11. Other (Specify): _____	-		-	-	-

	Applicant Requests Ltd	Full	Supervisor/ Consultant Recommends NR	Ltd	Full
B. Category II:					
1. Major diagnosis and therapy, but with no significant threat to life	-	-	-	-	-

Qualifications:

Physicians with significant training in the specialty related to diagnosis and therapy, i.e., full 3 - 6 months of training and experience within an approved obstetric training program, as in an Ob/GYN or Family Practice Residency, and experience in the care of the specific conditions.

Fully trained and certified nurse midwives must be able to demonstrate competence through training and experience to be granted privileges for manual removal of the placenta and for postpartum uterine exploration. An individual Certified Nurse Midwife who has had advanced training and experience may be granted privileges for low vacuum extraction delivery and/or Level I ultrasound.

Examples:

1. Category I					
2. Low forceps or vacuum extractor delivery	-	-	-	-	-
3. Manual removal of placenta and postpartum uterine exploration	-	-	-	-	-
4. Repair of third/fourth 'degree perineal laceration	-	-	-	-	-
5. Level I Ultrasound	-	-	-	-	-
6. Other (Specify): _____	-	-	-	-	-

c. Category III:

Major diagnosis and therapy with possible serious threat to life

Qualifications:

Physicians with completed residency training in the specialty or with extensive experience in the care of specific conditions.

	Applicant Requests Ltd	Full	Supervisor/ Consultant Recommends NR	Ltd	Full
- :					
1. Categories I and II	-	-	-	-	
2. All vaginal deliveries, including Breech delivery and Mid forceps delivery	-	-		-	
3. All cesarean deliveries	-	-	-	-	
4. Amniocentesis	-	-	-	-	
5. All high-risk pregnancies, including major medical diseases complicating pregnancy except intrauterine transfusion	-	-	-	-	
6. Other (Specify): _____	-	-	-		__

II. GYNECOLOGY:

A. Minor:

Physician with minimal formal training in the discipline but with training and experience in the care of the specific conditions.

Examples

1. I & D of vulvar or perineal abscess	-		-	-	-
2. Biopsy of vulva, vagina or cervix	-		-	-	-
3. Endometrial biopsy	-		-	-	-
4. Culdocentesis	-	-	-	-	-
5. Polypectomy	-	-	-	-	-
6. Curettage for incomplete abortion	-		-	-	-
7. Other (Specify): _____	-		-	-	-

B. Major:

Physician with completed residency training in the specialty or with extensive training or experience in the care of the specific conditions. Radical or exenterative procedures are generally excluded in the IHS clinical setting;

	Applicant Requests Ltd	Applicant Requests Full	Supervisor/ Consultant Recommends NR	Supervisor/ Consultant Recommends Ltd	Supervisor/ Consultant Recommends Full
Examples:					
1. Minor gynecologic surgery	-	-	-	-	-
2. All gynecologic illnesses and complications		-	-	-	-
3. Examination under anesthesia	=	-	-	-	-
4. Tubal sterilization	-	-	-	-	-
5. Abdominal hysterectomy	-	-	-	-	-
6. Salpingoophorectomy		-	-	-	-
7. Incidental appendectomy	--	-	-	-	-
8. Vaginal hysterectomy		-	-	-	-
9. Anterior C posterior repair	1	-	-	-	-
10. Urethropexy (abdominal and/or vaginal)	-	-	-	-	-
11. Laparoscopy	-	-	-	-	-
12. Other (Specify): _____	-	-	-	-	-

Note: All clinicians granted obstetrics privileges must also be qualified for and granted privileges in newborn resuscitation.

Circular Appendix 950160C.3

12/08/95

OMB No: 0917-0009
Expires: 07/31/98 _

ESTIMATED AVERAGE BURDEN TIME PER RESPONSE

The public reporting burden for completing this information collection is estimated to average 60 minutes. The estimate includes time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to: Reports Clearance Officer, Attention: PRA, United States Public Health Service, Hubert H. Humphrey Building, Room 721-B, 200 Independence Avenue, SW, Washington, D.C. 20201; reference Paperwork Reduction Project (0917-0009). DO NOT SW **COMPLETED FORMS TO THIS ADDRESS**.

SAMPLE

INDIAN HEALTH SERVICE
SURGICAL PRIVILEGES REQUEST FORM

INTRODUCTION: This Surgical Privileges Request Form must be accompanied or preceded by a completed application, for medical staff appointment, including the necessary supporting documents. Many clinical privileges pertinent to the practice of surgery and surgical specialties are Listed below. This list contains both outpatient and inpatient Items. The request for privileges must reflect both the applicant's and the facility/staff's ability to carry out or support the various functions. Documentation of training and/or experience in performIng various,surgical procedures must accompany this request. Any additional privileges may be requested on the Surgical Privileges Request Form or may be presented in an attached list and referenced on this form under "other."

INSTRUCTIONS FOR COMPLETING THE FORM

APPLICANT: With a check mark in the appropriate location, indicate for each item whether you are requesting LIMITED or FULL privileges. limited means that the applicant may function in the area of the stated clinical privileges on)y+under the direct supervision of a provider holding FULL privileges. E!J.& means that the applicant is entitled to function independently, following standards consistent with the medical community at large; in general, full surgical privileges require the completion of an accredited surgical residency. Be sure to sign the request as indicated on page 6;

DISCIPLINE-SPECIFIC SUPERVISOR OR CONSULTANT: Indicate your recommendation for each requested clinical privilege by placing a check mark in the appropriate location for either FULL, LIMITED, or NOT recommended (NR). Please explain any recommended limitations or denial of privileges on an attached sheet. Your recommendations are considered by the Governing Body when granting or not granting privileges.

SURGICAL PRIVILEGES REQUEST FORM

I. GENERAL SURGERY :

	Applicant Requests		Supervisor/ Consultant Recommends		
	NR	Ltd	Full	NR	Ltd	Full
A. skin:						
1. Skin tumors	-	-		-	-	
2. Split thickness grafts	-	-		-	-	
3. Wolfe grafts	-	-		-	-	
4. Pedicle grafts	-	-		-	-	
5. Skin lacerations	-	-		-	-	
6. Extensive burns	-	-		-	-	
7. Pilonidal cyst	-	-		-	-	
B. Head and neck:						
1. Parotid gland surgery	-	-		-	-	
2. Lip and tongue surgery	-	-		-	-	
3, Ranula	-	-		-	-	
4. Epulis	-	-		-	-	
5. Resection of jaw	-	-		-	-	
6. Thyroglossal ducts	-	-		-	-	
7. Branchial clefts	-	-		-	-	
8. Pharyngo-esoph. diverticulum	-	-		-	-	
9. Thyroidectomy	-	-		-	-	
10.Phrenic nerve	-	-		-	-	
c Abdominal and Rectal						
1. Paracentesis	-	-		-	-	
2. Gastroscopy	-	-		-	-	
3. Closure perforated ulcer	-	-		-	-	
4. Other gastric surgery	-	-		-	-	
5. Ramstedt Pyloromyotomy	-	-		-	-	
6. Gallbladder & common duct surgery	-	-		-	-	
7. Pancreatic surgery	-	-		-	-	
8. Splenectomy	-	-		-	-	
9. Small & large bowel surgery	-	-		-	-	
lO. Appendectomy	-	-		-	-	
ll. Abdomino-perineal resection	-	-		-	-	
12. Abdominal exploratory after work up	-	-		-	-	

	Applicant Requests Ltd	Full	Supervisor/ Consultant Recommends NR	Ltd	Full
13. I & D of intra-abdominal abscess	-	-	-		
14. Traumatic laparotomy,	—	-	-		-
15. Simple inguinal hernia	—	-	-	-	-
16. Strangulated or recurrent hernia	—	-	-	-	
17. Ventral or femoral hernia	—	-	-	-	
18. Proctosigmoidoscopy	—	-	-		-
19. Anoscopy	-	-	-	-	-
20. Hemorrhoidectomy	-	-	-	-	-
21. I & D Perirectal Abscess	-	-	-	-	
22. Fistula in ano	-	-	-	-	-
23. Liver biopsy, open	-	-	-	-	
24. Liver biopsy, closed	-	-	-	-	
D. Breast and Thoracic					
1. Breast biopsy	-	-	-	-	
2. Simple & radical mastectomy	-	-	-	-	-
3. Thoracentesis & closed drainage	-	-	-	-	-
4. Rib resection for empyema	-	-	-	-	-
5. Thoracoplasty	-	-	-	-	
6. Intrathoracic surgery	-	-	-	-	-
7. Surgery of diaphragm	—		-	-	-
E. Other:					
1. Hand infections (major)	-		-	- -	-
2. Hand infections (minor)	-	-	-	-	
3. Other (Specify): _____	C	-	-		-
II. VASCULAR SURGERY:					
A. Vein ligation & stripping	C				
B. Major vascular surgery	CI			-	
C. Arterial grafts	L	-		-	
D. Other (Specify):	L	-	-	-	
III. OPHTHALMOLOGIC:					
A. Chalazion	-	-	-		
B. Pterygium	-	-	-		-
C. Enucleation	-	-	-	-	-
D. I & D abscess of lid	-	-		-	
E. Cornea1 laceration	-	-		-	
F. Plastic on lids	L	-			-
G. Cataract	CI				-

	Applicant Requests		Supervisor/ Consultant Recommends		
	Ltd	Full	NR	Ltd	Full
H. Squint	-	-	-	-	-
I. Dacryocystectomy	-	-	-	-	-
3. Dacryocystorhlnostomy	-	-	-	-	-
K. Glaucoma	-	-	-	-	-
L. Retinal detachment	-	-	-	-	-
M. Laser therapy	-	-	-	-	-
N. Other (Specify):	-	-	-	-	-
IV. Ear, Nose and Throat (ENT):					
A. Tracheostomy	-	-	-	-	-
B. I & D abscess or hematoma of canal,or auricle	-	-	-	-	-
C. Laceration repair of nose or auricle	-	-	-	-	-
D. Foreign body removal from nose or ear	-	-	-	-	-
E. Complex laceration repair of nose/ear/face/neck	-	-	-	-	-
F. Tonsillectomy, adenoidectomy	-	-	-	-	-
G. Biopsy lesions of nose or auricle	-	-	-	-	-
H. Laryngoscopy	-	-	-	-	-
I. Nasal packing	-	-	-	-	-
J. Nasal fracture reduction	-	-	-	-	-
K. Reconstructive surgery of congenital deformities, including facial abnormalities (i.e., cleft lip and palate)	-	-	-	-	-
L. Split thickness skin graft	-	-	-	-	-
M. Full thickness skin graft	-	-	-	-	-
N. Bone, cartilage, alloplastic grafts	-	-	-	-	-
0. Blepharoplasty	-	-	-	-	-
P. Rotation flaps	-	-	-	-	-
Q. Myringotomy	-	-	-	-	-
R. Myringotomy with tube insertion	-	-	-	-	-
S. Excision of rhinophyma	-	-	-	-	-
T. Tympanotomy, tympanoplasty	-	-	-	-	-
U. Mastoidectomy, simple	-	-	-	-	-
V. Middle ear - removal of polyps, stapes mobilization	-	-	-	-	-
W. Otoplasty	-	-	-	-	-
X. Stapedectomy	-	-	-	-	-
Y. Rhinoplasty, septoplasty	-	-	-	-	-
2. Maxillo-facial injury repairs, including fractures	-	-	-	-	-

	Applicant Requests Ltd	Applicant Requests Full	Supervisor/ Consultant Recommends NR	Supervisor/ Consultant Recommends Ltd	Supervisor/ Consultant Recommends Full
AA. Excision of nasal mucosa, turbinates, polyps		-	-	-	-
BB. Sinusotomy	-	-	-	-	-
CC. Radical mastoidectomy	-	-	-	-	-
DD. Palatoplasfy		-	-	-	
EE. Lip resection	-	-	-	-	-
FF. Other (Specify): _____	-	-	-	-	-
v. **UROLOGICAL SURGERY:**					
A. Nephrectomy	-	-	-	-	
B. Pyelostomy	-	-	-	-	-
c. Ureterotomy		-	-	-	-
D. Cystostomy	-	-	-	-	-
E. Suprapubic prostatic resection n	-	-	-	-	
F. Other suprapubic bladder surgery	-	-	-	-	-
G. Cystectomy	-	-	-	-	-
H. Cystoscopy 6 retrograde pyelogram		-	-	-	
I. Transurethral cysto. & prostate surgery	-	-		-	
J. Hydrocele, spermatocele, varicocele	-	- ,		-	-
K. Vasectomy	-	-	-	-	-
L. Testicular surgery	-	-	-	-	-
M. Circumcision & meattfomy	-	-		-	
N. Major surgery of penis	-	-		-	
0. Other (Specify): _____		-	-		

Circular Appendix 95-16-C.3

12/08/95

SURGICAL PRIVILEGES REQUEST FORM

1. I hereby request the clinical privileges as indicated on the forms attached.

_____ _____
Applicant Date

2. I hereby recommend the clinical privileges as indicated.

_____ _____
Supervisor/Consultant Date

3. As Chairperson of the Medical Staff Executive Committee, I hereby recommend the clinical privileges: (Check one)

___ As noted.
___ With the following exceptions, deletions, additions, or conditions:

_____

_____ _____
Clinical Director Date

4. I hereby recommend the applicant for clinical privileges.

_____ _____
Service Unit Director Date

5. Privileges are hereby granted: (Check one)

___ As noted.
___ With the following exceptions, deletions, additions, or conditions:

_____

_____ _____
Chairperson of the Governing Body Date

Circular Appendix 95-16-C.4

12/08/95

OMB No: 0917-0009
Expires: 07/31/98

ESTIMATED AVERAGE BURDEN TIME PER RESPONSE

The public reporting burden for completing this information collection is estimated to average 60 minutes including time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of Information. Send comments regarding the burden this collection of information including suggestions for reducing this burden to: Reports Clearance Officer, Attention. United States Public Health Service, Hubert H. Humphrey Building, Room 721-B, 200 Independence Avenue, SW, Washington, D.C. 20201; and to the Office of Management and Budget, Paperwork Reduction Project (0917-0009). DO NOT RETURN COMPLETED FORMS TO THIS ADDRESS

SAMPLE

INDIAN HEALTH SERVICE
PSYCHIATRIC PRIVILEGES REQUEST tiRM

INTRODUCTION: This Psychiatric Privileges Request Form is, designed primarily for physicians who have completed a residency in psychiatry; (psychiatric privileges for non-psychiatric physicians are listed in section VII of the Medical Privileges Request Form). It must be accompanied or preceded by a completed application for medical staff appointment, including the necessary supporting documents. Many clinical privileges pertinent to the practice of psychiatry are listed below. The request for privileges must reflect both the applicant's and the facility/staff's ability to carry out or support the various functions. Any additional requested privileges shall be presented in an attached list and referenced on this form under "other. n

INSTRUCTIONS FOR COMPLETEING THE FORM

APPLICANT: With a check mark in the appropriate location, indicate for each item whether you are requesting LIMITED or FULL privileges. limited means that the applicant may function in the area of the stated clinical privileges only under the direct supervision of a provider holding Full privileges. FULL means that the applicant is entitled to function independently, following standards consistent, with the medical community at large. Be sure to sign the request as indicated on page 6,

DISCIPLINE-SPECIFIC SUPERVISOR OR CONSULTANT: Indicate your recommendation for each requested clinical privilege by placing a check mark in the appropriate location for either FULL, LIMITED, or NOT recommended (NR). Please explain any recommended limitations or denial of 'privileges on an attached sheet. Your recommendations are considered by the Governing Body when granting or not granting privileges.

Circular Appendix 95016-C.4

12/08/95

PSYCHIATRIC PRIVILEGES REQUEST FORM

Major General Psychiatric PRIVILEGES

	Applicant Requests		Supervisor/ Consultant Recommends		
	NR	Ltd	Full	NR	Ltd	Full
A. Diagnosis and Treatment of Adult:						
1. Affective disorders (unipolart bipolar) and dysthymic disorders	-	-	-	-	-
2. Schizophrenic disorders (including brief reactive psychosis)	-	-	-	-	-
3. Anxiety disorders	-	-	-	-	-
4. Substance use disorders	-	-	-	-	-
5. Somatoform disorders	-	-	-	-	-
6. Personality disorders & borderline states	-	-	-	-	-
7. Other (Specify): _____	-	-	-	-	-
B. Differential diagnosis of organic mental syndromes by by psychiatric, physical, by laboratory techniques	-	-	-	-	-
c. Differential diagnosis and treatment of neurO-psychiatric conditions including localizing and diffuse cortical pathology	-	-	-	-	
D. Differential diagnosis & treatment of emergency psychiatric conditions, including suicidal, acutely psychotic, assaultive, non-communicative, and drug and alcohol related syndromes	-	-	-	-	-
E. Adult Psychopharmacologic use of:					
1. Tricyclic antidepressants	-	-	-	-	-
2. Mono-amine oxidase inhibitors	-	-	-	-	-
3. Non-anaesthetic uses of neuroleptics	-	-	-	-	-
4, Benzodiazepines in the treatment of psychiatric disorders (especially anxiety)	-	-	-	-	-

	Applicant Requests		Supervisor/ Consultant Recommends		
	Ltd	Full	NR	Ltd	Full
5. Psychomotor stimulants	-	-	-	-	-
6. B-blockers for psychiatric use	-	-	-	-	-
7. Lithium carbonate- or citrate for psychiatric uses	-	-	-	-	-
8. Differential diagnosis and treatment of sleep disorders	-	-	-	-	-
G. Diagnosis & treatment of psycho-sexual disorders and non-physiologic sexual dysfunction	-	-	-	-	-
H. Individual psychotherapy of patients	-	-	-	-	-
I* Group psychotherapy	-	-	-	-	-
3. Family/couple therapy	-	-	-	-	-
K. Psychiatric program consultation	-	-	-	-	-
L. Psychiatric administratlve consultation	-	-	-	-	-
M. Diagnosis and treatment of addiction and habituation to DEA schedule I through V drugs	-	-	-	-	-
(NOTE: Must Conform to DEA regulations)					
N. Other (Specify): _____	-	-	-	-	-

II. Child Psychiatric Privileges:

A. Diagnosis and treatment in children & adolescents of:					
1. Schizophrenia and related disorders	-		-	-	-
2. Affective disorders	-	-	-	-	-
3. Autism	-	-	-	-	-
4. Anxiety disorders	-	-	-	-	-
5. Personality disorders	-		-	-	-
6. Psychosexual disorders	-		-	-	-
7. Substance use disorders	-		-	-	-
8. Psychological factors affecting physical condition	-		-	-	-
9. Anorexia Nervosa, Bulimia, eatina disorders	-		-	-	-

	Applicant Requests Ltd	Applicant Requests Full	Supervisor/ Consultant Recommend6 NR	Supervisor/ Consultant Recommend6 Ltd	Supervisor/ Consultant Recommend6 Full
10. Conduct disorders	-	-	-	-	-
11. Attention deficit disorder & hyperactivity	-	-	-	-	-
12. Enuresis, encopresis, sleep walking, and sleep terror	-	-	-	-	-
13. Tics (including Tourette's disorder)		-			
14. Identity disorders	-	-			
15. Attachment/object relations disorders		-	-	-	-
16. Other (Specify): _____		-	-	-	-
B. Diagnosis and treatment Of mental retardation	-	-	-	-	-
C. Diagnosis and treatment of developmental delays, learning disabilities, and specific neuro-psychiatric dysfunctional syndrome6	-	-	-	-	-
D. Use in children and early adolescent of:					
1. Antidepressants	-	-	-	-	-
2. Neuroleptics	-	-	-	-	-
3. Benzodiazepines		-	-	-	-
4. Psychomotor stimulants		-	-	-	-
5. Anticonvulsants for psychiatric purposes	-	-	-	-	-
6. Other medications with a primarily psycho-active pharmacologic effect	-	-	-	-	-
7. Other (Specify): _____		-	-	-	-
E. Individual psychotherapy, play therapy, behavioral therapy, and common child therapy		-	-	-	-
F. Emergency child psychiatric diagnosis and treatment of more common emergency child psychiatric Syndromes (e.g., suicide attempts, dissociative stages, psychotic presentations)	-	-	-	-	-
G. Other (Specify): _____			-	-	-

II. Minor Psychiatric Privileges:

	Applicant Requests Ltd	Applicant Requests Full	Supervisor/ Consultant Recommends NR	Supervisor/ Consultant Recommends Ltd	Supervisor/ Consultant Recommends Full
A. Forensic psychiatric privileges in:					
1. Civil proceedings:					
(a) Adult	-	-	-	-	-
(b) Child	-	-	-	-	-
2. Criminal proceedings:					
(a) Adult	-			-	-
(b) Child	-	-	-	-	-
B. Use of legally controlled treatment modalities including:					
1. Treatment of criminal sexual, offenders	-		-	-	-
2. Use of electro-convulsive therapy	-		-	-	-
3. Use of investigational drugs in treatment of psychiatric disorders	-		-	-	-
4. Other (Specify):	-	-	-	-	-
C. Diagnosis and treatment of epilepsy	-		-	-	-
D. Administration of individual psychological tests (e.g., MMPI, Bender, WAIS)	-		-	-	-
E. Treatment of chronic pain and illness behavior syndromes	-		-	-	-
F. Diagnosis/treatment of culture bound syndromes			-	-	-
G. Other (Specify): _____			-	-	-

Circular Appendix 95-16-C.4

12/08/95

PSYCHIATRIC PRIVILEGES REQUEST FORM

1. I hereby request the clinical privileges as indicated on the forms attached.

_____ _____
Applicant Date

2. I hereby recommend the clinical privileges as indicated.

_____ _____
Supervisor/Consultant 'Date

3. A6 Chairperson of the Medical Staff Executive Committee, hereby recommend the clinical privileges: (Check one)

   As noted.
   With the following exceptions, deletions, additions, or conditions:

_____ _____
Clinical Director Date

4. I hereby recommend the applicant for clinical privileges.

_____ _____
Service Unit Director Date

5. Privileges are hereby granted: (Check one)

   As noted.
   With the following exceptions, deletions, additions, or conditions:

_____ _____
Chairperson of the Governing Body Date

Circular Appendix 95-16-C.5

12/08/95

OMB No: 0917-0009
Expires: 07/31/98

ESTIMATED AVERAGE BURDEN TIME PER RESPONSE

The public reporting burden for completing this information collection is estimated to average 60 minutes. The estimate includes time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to: Reports Clearance Officer, Attention: PRA, United States Public Health Service, Hubert H. Humphrey Building, Room 721-B, 200 Independence Avenue, SW, Washington, D.C. 20201; reference Paperwork Reduction Project (0917-0009). DO NOT SEND COMPLETED FORMS TO THIS ADDRESS

SAMPLE

INDIAN HEALTH SERVICE
ANESTHESSA PRIVILEGES REQUEST FORM:

INTRODUCTION:

This Anesthesia Privileges Request Form must be accompanied or preceded by a completed application for medical staff appointment, including the necessary supporting documents. Most clinical privileges pertinent to the practice of anesthesia are listed below. The request for privileges must reflect both the applicant's and facility/staff's ability to carry out or support the various functions. Any additional privileges may be requested on the Anesthesia Privileges Request Form or may be presented in an attached list and referenced on this form under "other."

INSTRUCTIONS FOR COMPLETING THE FORM

APPLICANT:

With a check mark in the appropriate location, indicate for each item whether you are requesting LIMITED or FULL privileges. LIMITED means that the applicant may function in the area of the stated clinical privileges only under the direct supervision of a provider holding FULL privileges. FULL means that the applicant is entitled to function independently, following standards consistent with the medical community at large. Be sure to sign the request as indicated on page 6.

DISCIPLINE-SPECIFIC SUPERVISOR-CONSULTANT:

Indicate your recommendation for each requested clinical privilege by placing a check mark in the appropriate location for either FULL, LIMITED, or NOT recommended (NR). Please explain any recommended limitations *or* denial of privileges on an attached sheet. Your recommendations are considered by the Governing Body when granting or not granting privileges.

Assignment of clinical privileges in anesthesiology must be based upon:

1. Education
2. Clinical training
3. Capacity to manage procedurally related complications

THE SUGGESTED CLASSES OF CLINICAL PRIVILEGES ARE:

I. CLASS I PRIVILEGES:

Such privileges are to be granted to those members of the medical staff who are permitted to perform local infiltration anesthesia,, topical application, and mihor nerve blocks.

II.CLASS II PRIVILEGES

This class of privileges is assigned to those members of the, medical staff who are qualified to perform specific anesthetic procedures under specified conditions in addition to local infiltration, topical application, and minor nerve block class. The Anesthesia Privileges Request Form should be completed for these privileges.

III. CLASS III PRIVILEGES:

Privileges granted to those individuals who by training and experience are competent in:

A. The management of procedures for rendering a patient insensible to pain and emotional stress during surgical, obstetrical, and certain medical procedures.
8. The support of life functions under the stress of anesthetic and surgical manipulations.
c. The clinical management of the patient unconscious from whatever cause.
D. The management of problems in pain relief.
E. The management of problems in cardiac and respiratory resuscitation.
F. The application of specific methods of respiratory therapy.
G. The clinical management of various fluid, electrolyte, and metabolic disturbances.

Note: When Class III privileges are granted, they should be accompanied by specific limitations where indicated. The Anesthesia Privileges Request Form should be completed for these privileges.

ANESTHESIA PRIVILEGES REQUEST FORM

	Applicant Requests		Supervisor/ Consultant Recommends		
I General Anesthesia:	Ltd	Full	NR	Ltd	Full
A. Adult	-	-	-	-	-
B. Child	-	-	-	-	-
C. Inhalation agents	-	-	-	-	-
D. Intravenous agents	-	-	-	-	-
II. IV Sedation:					
A. Barbiturates	-	-	-	-	-
B. Catamenia	-	-	-	-	-
C. Narcotics	-	-	-	-	-
D. Major Tranquilizers '	-	-	-	-	-
III. Regional Anesthesia:					
A. Subarachnoid block	-	-	-	-	-
B. Lumbar epidural block	-	-	-	-	-
C. Brachial plexus block	-	-	-	-	-
D. Sciatic - Femoral block	-	-	-	-	-
E. Ankle block	-	-	-	-	-
F. Cervical epidural	-	-	-	-	-
G. Thoracic epidural	-	-	-	-	-
H. Other (Specify): _____					
I v . p a i n :					
A. Differential subarachnoid block	-	-	-	-	-
B. Lumbar sympathetic block	-	-	-	-	-
C. Stellate ganglion block	-	-	-	-	-
D. Epidural steroids	-	-	-	-	-
E. Epidural narcotics	-	-	-	-	-
F. Celiac plexus block	-	-	-	-	-
G. Intercostal nerve block	-	-	-	-	-
H. Neurolytic block					

v. Subspecialty Anesthesia:	Applicant Requests Ltd	Applicant Requests Full	Supervisor/ Consultant Recommends NR	Supervisor/ Consultant Recommends Ltd	Supervisor/ Consultant Recommends Full
A. Infants:	-	-	-	-	-
(1) Routine	-	-	-	-	-
(2) High risk					
B. Thoracic surgery:	-	-	-	-	-
(1) Adult	-	-	-	-	-
(2) Child	-	-	-	-	-
(3) Infant					
C. Intracranial surgery:	-	-	-	-	-
(1) Adult	-	-	-	-	-
(2) Child	-	-	-	-	-
(3) Infant					
D. Major vascular surgery	-	-	-	-	-
E. Caesarean section					
VI. Monitoring:					
A. Radial artery catheterization	-	-	-	-	-
B. CVP line placement:	-	-	-	-	-
(1) Peripheral	-	-	-	-	-
(2) Internal Jugular	--	-	-	-	-
(3) Subclavian					
C. Pulmonary artery catheterization	-	-	-	-	-
VII. Special Techniques:					
A. Deliberate hypotension	—	-	-	-	-
B. Deliberate hypothermia	—	-	-	-	-

	Applicant Requests		Supervisor/ Consultant Recommends		
VIII. managemant:					
A. Awake:					
1. Oral	-		-	-	-
2. Nasal		-	-	-	-
B. Anesthetized:					
1. Oral	-	-	-	-	-
2. Nasal	-	-	-	-	-
IX. Ventilator:	-	-	-	-	-
x. Interpretation of ABG's:	-	-	-	-	-
xi. Interpretation of PFT'S:	-	-	-	-	-
XII. Interpretation of EKG'S:	-	-	-	-	-
XIII. SUPERVISION OF CRNA'S	-	-	-	-	-

Circular Appendix 95-16-C.5

12/08/95

ANESTHESIA PRIVILEGES REQUEST FORM

1. I hereby request the clinical privileges as indicated on the forms attached.

_____ _____
Applicant Date

2. I hereby recommend the clinical privileges as indicated.

_____ _____
Supervisor/Consultant Date

3. As Chairperson of the Medical Staff Executive Committee, I hereby recommend the clinical privileges: (Check one)

___ As noted.
___ With the following exceptions, deletions, additions, or conditions:

_____ _____
Clinical Director Date

4. I hereby recommend the applicant for clinical privileges.

_____ _____
Service Unit Director Date

5. Privileges are hereby granted: (Check one)

___ As noted.
___ With the following exceptions, deletions, additions, or conditions:

_____ _____
Chairperson of the Governing Body Date

Circular Appendix 95-16-C.6

12/08/95

OMB N: 0917-0009
Expires: 07/31/98

ESTIMATED A- BURDEN TIME PER RESPONSE

The public reporting burden for completing this information collection is estimated to average 60 minutes. The estimate includes time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to: Reports Clearance Officer, Attention: PRA, United States Public Health Service, Hubert H. Humphrey Building, Room 721-B, 200 Independence Avenue, SW, Washington, D.C. 20201; reference Paperwork Reduction Project (0917-0009). DO NOT SEND COMPLETED FORMS TO THIS ADDRESS.

SAMPLE

INDIAN HEALTH SERVICE
DENTAL PRIVILEGES REQUEST FORM

INTRODUCTION:

The Dental Privileges Request Form must be accompanied or preceded by a completed application for medical staff appointment, including the necessary supporting documents. Most clinical privileges pertinent to the dental program of your assigned facility are listed below. The definitions of the privileges are found in the Indian Health Service document "ADA Code Definitions for the IHS Direct Care Program."

INSTRUCTIONS FOR COMPLETING THE FORM:

APPLICANT: With a check mark in the appropriate location, indicate for each item whether you are requesting LIMITED or FULL privileges. LIMITED means that the applicant may function in the area of the stated clinical privileges only under the direct supervision of a provider holding FULL PRIVILEDGES. FULL means that the applicant is entitled to function independently, following standards consistent with the dental community at large. Be sure to sign the request as indicated on page 5.

DISCIPLINE SPECIFIC SUPERVISOR OR CONSULTANT.

Indicate your recommendation for each requested clinical privilege by placing a check mark in the appropriate location for either FULL, LIMITED, or NOT recommended (NR). Please explain any recommended limitations or denial of privileges on an attached sheet. Your recommendations are considered by the Governing Body when granting or not granting privileges.

Circular Appendix 95-16-C.6

12/08/95

DENTAL PRIVILEGES REQUEST FORM

		Applicant Requests		Supervisor/ Consultant Recommends		
I.	ENDODONTIC PROCEDURES:					
		Ltd	Full	NR	Ltd	Full
A.	Anterior Root Canal Therapy	-	-	-	-	-
B.	Bicuspid Root Canal Therapy	-	-	-	-	-
c.	Molar Root Canal Therapy	-	-	-	-	-
D.	Endodontic surgery	-	-	-	-	-
II.	PERIODONTICS:					
A.	Mucogingival Surgery	-	-	-	-	-
8.	Osseous Surgery	-	-	-	-	-
c.	Osseous Graft	-	-	-	-	-
D.	Free Soft Tissue Grafts	-	-	-	-	-
E.	Splinting	-	-	-	-	-
F.	Occlusal Adjustment Limited	-	-	-	-	-
G.	Occlusal Adjustment - Complete	-	-	-	-	-
H.	Special Periodontal Appliances (occlusal guard)	-	-	-	-	-
III.	REMOVABLE PROSTHODONTICS:					
A.	Complete Dentures	-	-	-	-	-
B.	Immediate Dentures	-	-	-	-	-
c.	Partial Dentures	-	-	-	-	-
D.	Obturator for Cleft Palate	-	-	-	-	-
E*	Overdenture - Complete/Partial	-	-	-	-	-
F.	Special Appliances (Specify) _____	-	-	-	-	-
IV.	ORAL SURGERY:					
A.	Routine Tooth Extractions		-	-	-	-
B.	Surgical Extraction-Erupted Tooth	-	_	_	___	_
c.	Surgical Extraction Tissue Impaction			-	-	-
D.	Surgical Extraction-Bone Impaction	-	-	_	-	___
E.	Surgical Extraction-Impaction Requiring Sectioning of Tooth			-	-	-
F.	Residual Root Recovery by Surgery	-	-	_	___	___

		Applicant Requests		Supervisor/ Consultant Recommends		
		Ltd	Full	NR	Ltd	Full
G.	Oral Antral Fistula Closure		-	-	v	-
H.	Antral Root Recovery		-	-	w	-
I.	Tooth Replantation	-	-	-	w	-
J.	Tooth Transplantation	-	-	-	-	-
K.	Surgical Exposure of Impacted or Unerupted Tooth for Orthodontic Reasons		-	-	m	-
L.	Surgical Exposure of Impacted *or* Unerupted Tooth to Aid Eruption	-	-	-	-	-
M.	Biopsy of Oral Tissue (hard)	-	-			
N.	Biopsy of Oral Tissue (soft)		-	-	-	-
0.	Alveoloplasty per Quadrant in Conjunction with Extractions		-			
P.	Alveoloplasty per Quadrant not in Conjunction with Extractions		-	-	-	-
Q.	Stomatoplasty per Arch- * Uncomplicated	-	-	-	-	-
R.	Stomatoplasty per Arch-Complicated	-	-	-	-	-
s.	Surgical Excision	-	-	-	-	-
T.	Destruction of Lesion by Physical Methods (electrosurgery)		-	-	v	-
u.	Removal of Exostosis - Maxilla/Mandible		-	-	w	-
v.	Incision & Drainage of-Abscess (Intraoral)		-	—	—	—
w.	Incision & Drainage of Abscess (Extraoral)	-	-	-	-	-
x.	Removal of Foreign Body, Skin, or Subcutaneous Alveolar Tissue	-	-	-	-	-
Y.	Maxilla Closed Reduction, Teeth Immobilized (if present)	-	-	-	w	-
2.	Mandible Open Reduction (Intraoral)	-	-	-	v	-
AA.	Mandible Closed Reduction		-	-	-	-
BB.	Malar/Zygomatic Arch Closed Reduction		-	—	—	—
CC.	Alveolus Stabilization o f Teeth, Open Reduction, Splinting		-	-	v	-
DD.	Closed Reduction of TMJ Dislocation	-	-	-	w	-
EE.	Frenulectomy	-	-	-	-	-
FF.	Emergency Tracheotomy	-	-	-	-	7
GG.	Suturing of Traumatic Wounds (intraoral)	-	-	—	—	—
HH.	Suturing of Traumatic Wounds (extraoral)	-		—	—	—

		Applicant Requests		Supervisor/ Consultant Recommends		
V.	**ORTHODONTICS:**					
		Ltd:	Full	NR	Ltd	Full
A.	Removable Appliance - Maxillary Arch	-	-		-	
B.	Removable Appliance - Mandibular Arch	-	-		-	
c.	Fixed Appliances - Maxillary Arch (minor tooth movement)	-	-	-		
D.	Fixed Appliance - Mandibular Arch (minor tooth movement)	-	-	-	-	-
E.	Functional Appliances		-		-	-
F.	Comprehensive Orthodontic Treatment z		-	-		
VI.	ADJUNCTIVE SERVICES: ,					
A.	N2O Analgesia	-	-	-		
B .	IV Sedation	-	-	-	-	
c.	Therapeutic Drug Injection	-	-	-	-	-
D.	Oral Sedation	-			-	-

DENTAL PRIVILEGES REQUEST FORM

1. I hereby request the clinical privileges as indicated on the forms attached.

_____ _____
Applicant Date

2. I hereby recommend the clinical privileges as indicated.

_____ _____
Supervisor/Consultant Date

3. As Chairperson of the Medical Staff Executive Committee, I hereby recommend the clinical privileges: (Check one)

- As noted.
- With the following exceptions, deletions, additions, or conditions:

_____ _____
Clinical Director Date

4. I hereby recommend the applicant for clinical privileges.

_____ _____
Service Unit Director Date

5. Privileges are hereby granted: (Check one)

- As noted.
- With the following exceptions, deletions, additions, or conditions:

_____ _____
Chairperson of the Governing Body Date

Circular Appendix 95-16-C.7

12/08/95

OMB No: 0917-0009
Expires: 07/31/98

ESTIMATED AVERAGE BURDEN TIME PER RESPONSE

The public reporting burden for completing this information collection is estimated to average 20 minutes. The estimate includes time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to: Reports Clearance Officer, Attention: PHA, United States Public Health Service, Hubert H. Humphrey Building, Room 721-B, 200 Independence Avenue, SW, Washington, D.C. 20201; reference Paperwork Reduction Project (0917-0009). DO NOT SEND **COMPLETED FORMS TO THIS ADDRESS**.

S A M P L E

INDIAN HEALTH SERVICE
OPTOMETRIC PRIVILEGES REQUEST FORM

INTRODUCTION:

The Optometrist clinical privilege application must be accompanied, or preceded, by a completed application for medical staff appointment, including the necessary supporting documents. The most common privileges practiced by optometrists will be found in this document, but many may still have to be added by the applicant. This can be done by "writing in" additional privileges on the bottom of page.

INSTRUCTIONS FOR COMPLETING THE FORM

APPLICANT:

With a check mark in the appropriate location, indicate for each item if privileges are requested. Be sure to sign the request as indicated on page 6.

DISCIPLINE SPECIFIC SUPERVISOR OR AREA OPTOMETRY CONSULTANT:

Indicate your recommendation for each requested clinical privilege by placing a check mark in the appropriate location. This recommendation is considered by the privilege granting authority. Be sure to sign the request as indicated on page 6. Recommended limitations or denial of privileges must be explained in detail on an attached sheet.

Note: Any patient admitted to an IHS hospital for ocular procedures must have an admission history and physical exam conducted by a physician member of that hospital's medical staff. Any non-ocular medical problem(s) present on admission, and any which occur during the hospital stay must be evaluated and managed by a physician member of that hospital's medical staff.

CREDENTIALS AS EVIDENCE OF COMPETENCY

I. Class I Optometric Privileges:

A. EDUCATION: A Degree of Doctor of Optometry is required from one of the schools or colleges of optometry listed as accredited by the Council on Optometric Education of the American Optometric Association (COEAOA).

B. LICENSURE: Full and unrestricted license is required to practice optometry in a State, Territory, or District of Columbia, if hired as a civil servant. A commissioned officer of the U.S. Public Health Service (USPHS) must meet the USPHS Optometry appointment standards.

II. GLASS II Optometric Privileges

An optometrist is eligible for additional clinical privileges, if the following credentials are provided:

A. A license to practice optometry and State certification to use therapeutic pharmaceutical agents.

B. If (A) is not satisfied, evidence of one or more of the following is required:

1. Training or experience such that the optometrist now holds IHS privileges or equivalent, consistent with appropriate portions of Class II privileges, and these privileges, have been and regularly reviewed over the prior two or more years.

2. Successful completion of at least 1 year of post-graduate training in a fellowship or primary care residency program accredited by the COEAOA.

3. Diplomate of the American Academy of Optometry in ocular disease in primary care.

4. Successful completion of a minimum 106-hour course in the management of ocular diseases and/or conditions as certified by an accredited optometric educational institution.

5. A passing score on a national certifying examination in the treatment and management of ocular diseases and/or conditions.

OPTOMETRY PRIVILEGES REQUEST FORM

I. **Class I Optometric Privileges:**

		Applicant Requests		Supervisor/ Consultant Recommends*		
		Ltd	Full	NR	Ltd	Full
A.	General optometric examination, diagnosis and optical therapy	-	-			
B.	Medical laboratory studies	-	-			
c.	Ocular imaging studies	—	-			—
D.	Photo documentation	—	-			
E.	Diagnostic pharmaceutical agents	—	-	-		
F.	Extended posterior segment evaluation		-			
G.	Visual fields testing/evaluation		-			
H.	Low vision management ,	-	-	-	-	-
I.	Contact lens management	-	-	-	-	-
J.	Oculomotor/perceptual/pupillary problems		-			
K.	Non-invasive management of lid conditions		-			
L.	Non-invasive care of external eye injuries/burns		-			
M.	Epilation of lashes		-		-	-
N.	Conjunctivitis therapy with topical medications	-	-		-	-
0.	Lacrimal function evaluation (non-invasive)		-			
P.	Cornea1 abrasion care		-			-
Q.	Nonperforating foreign substance removal		-			
R.	Management of keratitis-sicca and other epithelial keratitis (non microbial)	-	-			-
S.	Gonioscopy		-			-
T.	OTC oral medications for ocular disease	-	-	-	-	-
u.	Emergency treatment of life/sight threatening condition prior to referral	-	-	-	-	-
V.	Other (Specify): _____		-			

II. **Class I**I optometric Privileges:

The necessary,phamaceutical agents are approved to complete the indicated diagnostic/non-invasive therapeutic procedures for the following:

		Applicant Requests		Supervisor/ Consultant Recommends*		
		Ltd	Full	NR	Ltd	Full
A.	Ultrasound measurement/evaluation	-	-	-	-	-
B.	Punctum dilation/plugs/irrigation	-	.-		-	-
c.	Anterior uveitis care	-	-			-
D.	Medical hyphema management	-	-	-	-	-
E.	Open angle glaucoma			-	-	-
F.	Acute glaucoma	-	-		-	-
G.	Lids and periorbital skin conditions	-	-	-	-	-
H.	Keratitis			-	-	-
I.	Episcleritis				-	-
J.	Post-surgical eye care	-	-			-
K.	Other (Specify): _____	-	-			-

* This person is always an optometrist.

Circular Appendix 95-16-C.7

12/08/95

OPTOMETRY PRIVILEGES REQUEST FORM

1. I hereby request the clinical privileges as indicated on the forms attached.

_____ _____
Applicant Date

2. I hereby recommend the clinical privileges as indicated.

_____ _____
Service Unit O.D. or Area Optometry Consultant Date

Concur with Service Unit O.D.: _____

3. As Chairperson of the Medical Staff Executive Committee, I hereby recommend the clinical privileges: (Check one)

___ As noted.
___ With the following exceptions, deletions, additions, or conditions:

_____ _____
Clinical Director Date

4. I hereby recommend the applicant for clinical privileges.

_____ _____
Service Unit Director Date

5. Privileges are hereby granted: (Check one)

- As noted.
- With the following exceptions, deletions, additions, or conditions:

_____ _____
Chairperson of the Governing Body Date

Circular Appendix 95-160C.8

12/08/95

OMB No: 0917-0009
Expires: ,7/31/98

ESTIMATED A- BURDEN TIME PER RESPONSE

The public reporting burden for completing this information collection is estimated to average 20 minutes. The estimate includes time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to: Reports Clearance Officer, Attention: PRA, United States Public Health Service, Hubert ii. Humphrey Building, Room 721-B, 200 Independence Avenue, SW, Washington, D.C. 20201; reference Paperwork Reduction Project (0917-0009). DO NOT SEND COMPLETED FORMS TO THIS

SAMPLE

INDIAN HEALTH SERVICE
PSYCHOLOGY PRIVILEGES REQUEST FORM

INTRODUCTION:

This Psychology Privileges Request Form must be accompanied or preceded by a completed application for medical staff appointment, including the necessary supporting documents. Many clinical privileges pertinent to the practice of psychology are listed below.

INSTRUCTIONS FOR COMPLETING THE FORM

APPLICANT: With a check mark in the appropriate location, indicate for each item whether you are requesting LIMITED or FULL privileges. LIMITED means that the applicant may function in the area of the stated clinical privileges only under the direct supervision of a provider holding FULL privileges. FULL means that the applicant is entitled to function independently, following standards consistent with the clinical psychology community at large. Be sure to sign the request as indicated on page 4.

DISCIPLINE SPECIFIC SUPERVISOR OR CONSULTANT: Indicate your recommendation for each requested clinical privilege by placing a check mark in the appropriate location for either FULL, LIMITED or NOT recommended (NR). Please explain any recommended limitations or denial of privileges on an attached sheet. Your recomendations are considered by the Governing Body when granting *or* not granting privileges.

PSYCHOLOGY PRIVILEGES REQUEST FORM

I. CLINICAL ATTENDING PRIVILGES:

	Applicant Requests Ltd	Full	Supervisor/ Consultant Recommends NR	Ltd	Full
A. Patient Management Privileges:					
1. Admit patients		-			
2. Discharge patients	-	-			
3. Coordinate/provide psychological care	-	-			
4. Write and sign treatment plans		-			
5. Write orders for assessment and treatment procedures		-	-	-	-
6. Write orders for medical consultation		-			
7. Participate on multi-disciplinary treatment teams	-	-			
8. Enter consultation notes on charts		-			
9. Other (Specify): _____		-	-	-	-
B. Clinical Assessment Privileges:					
1. Behavioral assessment		-			
2. Biobehavioral and psychophysiological assessment examinations	-	-			
3. Neuropsychological examination	-	-			
4. Mental status examination	-	-			
5. Intellectual assessment	-	-			
6. Developmental assessment		-			
7. Personality assessment		-			
8. Trauma assessment	-	-			
9. Differential diagnostic assessment	-	-			
10. Forensic assessment		-			
11. Psychopharmacologic response monitoring		-			
12. Vocational/education assessment	__	-			
13. Psychosocial assessment	-	-			
14. Other assessment, as indicated	__	-			

	Applicant Requests		Supervisor/ Consultant Recommends		
	Ltd	Full	NR	Ltd	Full
c. Clinical Treatment Privileges:					
1. Individual psychotherapy	-	-		-	
2. Group psychotherapy	-	-		-	-
3. Family psychotherapy	-	-		-	-
4. Behavior modification		-	-		-
5. Hypnosis		-	-	-	
6. Biofeedback		-	-	-	
7. Emergency room/crisis intervention		-		-	-
8. Pain management		-			-
9. Substance abuse reduction		-	-		
10. Stress management	-	-	-	-	-
11. Rehabilitation services	-	-		-	-
12. Other, (Specify): ,_____		-			-
II. CONSULTING PRIVILEGES					
A. Within the Facility:					
1. Consultation liaison to other services		-			
2. Organizational developmental services		-	-		
3. Staff development	-	-	-	-	
4. Wellness promotion	-	-			
B. External to the Facility:					
1. Professional and community education	-	-			
2. Community development		-	-		
3. Disease/injury prevention		-	-	-	
III. PROGRAMMATIC ACTIVITIES					
A. Program planning and evaluation	-	-	-	-	-
B. Collection/interpretation of caseload date		-	-	-	-
c. Ascertainment of population mental health needs		-			-
D. Supervise staff and trainees		-			
E. Ensure accreditation/approval					

PSYCHOLOGY PRIVILEGES REQUEST FORM

1. I hereby request the clinical privileges as indicated on the forms attached.

_____ _____
Applicant Date

2. I hereby recommend the clinical privileges as indicated.

_____ _____
Supervisor/Consultant Date

3. As Chairperson of the Medical Staff Executive Committee, I hereby recommend the clinical privileges: (Check one)

- As noted.
- With the following exceptions, deletions, additions, or conditions:

_____ _____
Clinical Director Date

4. I hereby recommend the applicant for clinical privileges.

_____ _____
Service Unit Director Date

5. Privileges are hereby granted: (Check one)

- As noted.
_ With the following exceptions, deletions, additions, or conditions:

_____ _____
Chairperson of the Governing Body Date

Circular Appendix 95-16-C.9

12/08/95

OMB No: 0917-0009
Expires: 07/31/98

ESTIMATED AVERAGE BURDEN TIME PER RESPONSE

The public reporting burden for completing this information collection is estimated to average 10 minutes. The estimate includes time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to: Reports Clearance Officer, Attention: PRA, United States Public Health Service, Hubert H. Humphrey Building, Room 721-B, 200 Independence Avenue, SW, Washington, D.C. 20201; reference Paperwork Reduction Project (0917-0009). DO NOT SEND COMPLETED FORMS TO THIS ADDRESS

SAMPLE

INDIAN HEALTH SERVICE
AUDIOLOGIC PRIVILEGES REQUEST FORM

INTRODUCTION:

This Audiologic Privileges Request Form must be accompanied or preceded by a completed application for medical staff appointment, including the necessary supporting documents. The request for privileges must reflect both the applicant's and the facility/staff's ability to carry out or support the various functions.

INSTRUCTIONS FOR COMPLETING THE FORM

APPLICANT: With a check mark in the appropriate location, indicate for each item, if you are requesting privileges. Be sure to sign the request as indicated on Page 3.

DISCIPLINE SPECIFIC SUPERVISOR OR CONSULTANT: Indicate your recommendation for each requested clinical privilege by placing a check mark in the appropriate location for either NO or YES. Please explain any recommended limitations or denial of privileges on an attached sheet. Your recommendations are considered by the Governing Body when granting or not granting privileges.

AUDIOLOGIC PRIVILEGES REQUEST FORM

I. DIAGNOSTIC:	Applicant Requests Ltd	Applicant Requests Full	Supervisor/ Consultant Recommends NR	Supervisor/ Consultant Recommends Ltd	Supervisor/ Consultant Recommends Full
A. Pure tone audiometry	-	-	-	-	
B. Speech audiometry	-	-	-	-	
C. Site of lesions tests (auditory)		-		-	-
D. Acoustic-impedance measurements	A		-		-
E. Electronystagmography	-	, -	-	-	
F. Pediatric audiometry		-		-	-
G. Evoked potential (auditory)		-	-		-
II. AMPLIFICATION:					
A. Assessment of potential success of amplification			-	-	
B. Hearing aid evaluation		-		-	-
C. Issuing hearing aids		-		-	-
III. REHABILITATION					
A. Auditory training	-		-		-
B. Manual communication	-		-	-	
C. Speech reading	-	-	-	-	
D. Non-verbal commmunication		-		-	-

Circular Appendix 95-16-C.9

12/08/95

AUDIOLOGIC PRIVILEGES REQUEST FORM

1. I hereby request the clinical privileges as indicated on the forms attached.

_____ _____
Applicant Date

2. I hereby recommend the clinical privileges as indicated.

_____ _____
Supervisor/Consultant Date

3. As Chairperson of the Medical Staff Executive Committee, I hereby recommend the clinical privileges: (Check one)

___ As noted.
___ With the following exceptions, deletions, additions, or conditions:

_____ _____
Clinical Director Date

4. I hereby recommend the applicant for clinical privileges.

_____ _____
Service Unit Director **Date**

5. Privileges are hereby granted: (Check one)

As noted.
With the following exceptions, deletions, additions, or conditions:

_____ _____
Chairperson of the Governing Body Date

Circular Appendix 95-16-C.10

12/08/95

OMB No: 0917-0009
Expires: 07/X/98

ESTIMATED AVERAGE BURDEN TIME PER RESPONSE

The public reporting burden for completing this information collection is estimated to average 5 minutes. The estimate includes time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to: Reports Clearance Officer, Attention: PRA, United States Public Health Service, Hubert H. Humphrey Building, Room 721-B, 200 Independence Avenue, SW, Washington, B.C. 20201; reference Paperwork Reduction Project (O9l7-000s). DO NOT SEND **COMPLETED FORMS TO THIS ADDRESS**.

SAMPLE

INDIAN HEALTH SERVICE
PODIATRIC PRIVILEGES REQUEST FORM

INTRODUCTION:

This Podiatric Privileges Request Form must be accompanied or preceded by a completed application for medical staff appointment, including the necessary supporting documents. Many clinical privileges pertinent to the practice of podiatry and podiatric surgery are listed below. This list contains both outpatient and inpatient items, and the request for privileges must reflect both the applicant's and the facility/staff's ability to carry out or support the various functions.

INSTRUCTIONS FOR COMPLETING THE FORM

APPLICANT: With a check mark in the appropriate location, indicate for each item, if you are requesting privileges. Be sure to sign the request as indicated on page 3.

DISCIPLINE-SPECIFIC SUPERVISOR OR CONSULTANT: Indicate your recommendation for each requested clinical privilege by placing a check mark in the appropriate location. Please explain any recommended limitations or denial of privileges on an attached sheet. Your recommendations are considered by the Governing Body when granting or not granting privileges.

Note: Any patient admitted to an IHS hospital for inpatient podiatric surgery or care must, by prior agreement, have an admission history and physical exam done by a physician member of that hospital's medical staff. Any medical problems present on admission and any which occur during the hospital stay must be managed by that physician or his/her physician designee. Any patient undergoing outpatient podiatric surgery in any IHS facility must likewise be under the care of one of that facility's physician members of the medical staff for medical needs.

PODIATRIC PRIVILEGES REQUEST FORM

		Applicant Requests		Supervisor Consultant Recommends		
		Ltd	Full	NR	Ltd	Full
1.	Office-based, non-surgical podiatric care, including examinations, consultation, and non-invasive procedures	-	-	—	—	—
2.	Toenail surgery, including removal	-		—	—	—
3.	Arthroplasty of the lesser digits	-		—	—	—
4.	Simple cutaneous lesions excision			—	—	—
5.	Simple tenotomy/capsulotomy of the forefoot	-		—	—	—
6.	Simple bunionectomy	-		—	—	—
7.	complex bunionectomy (Keller, Mitchell, Chevian, etc.)		-	—	—	—
8.	Removal of foreign bodies		-	—	—	—
9.	Excision of neuromas	-	-	—	—	—
10.	Forefoot sesamoidectomy	-		—	—	—
11.	Tailor's bunionectomy	-		—	—	—
12.	Excision of dorsal metatarsal cuneiform exostosis			-	-	-
13.	Osteotomy of the lesser metatarsals			-	-	-
14.	Plantar condylectomy, lesser metatarsals			-	-	-
15.	Excision or resection, metatarsal-phalangeal arthroplasty or hemi-arthroplasty of the lesser toes			-	-	-
16.	Excision of subcutaneous lesions, including lipomas, fibromas, and ganglions			—	—	—
17.	Ostectomy of the lesser toe phalanges	-		—	—	—
18.	Interphalangeal excision arthroplasty or arthrodesis	-		—	—	—

Circular Appendix 95-16-C.10

12/08/95

PODIATRIC PRIVILEGES REQUEST FORM

1. I hereby request the clinical privileges as indicated on the forms attached.

_____ _____
Applicant Date

2. I hereby recommend the clinical privileges as indicated.

_____ _____
Supervisor/Consultant Date

3. As Chairperson of the Medical Staff, Executive Committee, I hereby recommend the clinical privileges: (Check one)

- As noted.
_ With the following exceptions, deletions, additions, or, conditions:

_____ _____
Clinical Director Date

4. I hereby recommend the applicant for clinical privileges.

_____ _____
Service Unit Director Date

5. Privileges are hereby granted: (Check one)

As noted.
With the following exceptions, deletions, additions, or conditions:

_____ _____
Chairperson of the Governing Body Date

Circular Appendix 9-16-C.11

12/08/95

OMB No: 0917-0009
Expires: 07/31/98

ESTIMATE33 A- BURDEN TIME PER RESPONSE

The public reporting burden for completing this information collection is estimated to average 5 minutes. The estimate includes time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to: Reports Clearance Officer, Attention: PRA, United States Public Health Service, Hubert H. Humphrey Building, Room 721-B, 200 Independence Avenue, SW, Washington, D.C. 20201; reference Paperwork Reduction Project (0917-0009). DO NOT SEND COMPLETED FORMS TO THIS ADDRESS.

SAMPLE

INDIAN HEALTH SERVICE
RADIOL0GY PRIVILEGES REQUEST FORM

INTRODUCTION:

The Radiology Privileges Request Form must be accompanied or preceded by a complete application for medical staff appointment, including the necessary supporting documents. Many clinical privileges pertinent to the practice of radiology are listed **below.** The request for privileges must reflect both the applicant's and the facility/staff's ability to carry out or support **the** various functions. Documentation of training and/or experience in performing various procedures/modalities must accompany this request. Any additional privileges may be requested on the form or may be presented in an attached list.

INSTRUCTIONS FOR COMPLETING THE FORM

APPLICANT: **With** a check mark in the appropriate location, indicate for each item whether you are requesting either LIMITED or FULL privileges. LIMITED means that the applicant may function in the area of the stated clinical privileges only under the direct supervision of a provider holding FULL privileges. FULL means that the applicant is entitled to function independently, following standards consistent with the medical community at large. . Be sure to sign the request as indicated on page 4.

DISCIPLINE SPECIFIC SUPERVISOR OR CONSULTANT:

Indicate your recommendation for each requested clinical privilege by placing a check mark in the appropriate location for either FULL, LIMITED, or NOT recommended (NR). Please explain any recommended limitations or denial of privileges on an attached sheet. This recommendation is considered by the governing body when granting or not granting privileges.

RADIOLOGY PRIVILEGES REQUEST FORM

I. RADIOGRAPHIC:

	Applicant Requests Ltd	Applicant Requests Full	Supervisor/ Consultant Recommends NR	Supervisor/ Consultant Recommends Ltd	Supervisor/ Consultant Recommends Full
A. General diagnostic roentgenology		-		-	
B. Barium studies; including small bowel enterolysis and air-contrast barium enemas		-		-	
C. Intravenous pyelography		-		-	-
D. Fistula and sinus tract studies	-	-	-		-
E. Myelography (cervical, lumbar, & thoracic)	-	-	-	-	
F. Other (Specify): _____		-		-	-

II. COMPUTERIZED EXAMINATIONS :

A. Head (Including temporal bone and Pituitary)		-			-
B. Neck (Including salivary glands, and larynx)	-	-			-
C. Chest	-	-			-
D. Abdomen	-	-	-		-
E. Pelvis	-	-	-		
F. Spine	-		-	-	
G. Extremities	-	-		-	-
H. Other (Specify): _____	-	-			-

III. 7 :

A. Aortic sonography	-	-	-		-
8. Obstetrical sonography	-	-	-	-	
C. Biophysical profile	-	-		-	-
D. Gallbladder sonography	-	-			-
E. Liver sonography	-	-	-		
F. Pancreatic sonography	-	-	-	-	
G. Splenic sonography	-	-	-	-	
H. Pelvic sonography	-	-		-	-
I. Renal sonography	-	-			-
J. Thyroid sonography	-	-			-

		Applicant Requests Ltd	Applicant Requests Full	Supervisor/ Consultant Recommends NR	Supervisor/ Consultant Recommends Ltd	Supervisor/ Consultant Recommends Full
K.	Vascular sonography	—	—	-	-	-
	1. Deep venous (abd/extrem, etc.)	—	-	-	—	—
	2. Carotid	-	-	—	—	—
L.	Sonography of soft tissue masses or fluid collections	-	-	-	—	—
M.	Sonography for thoracentesis guidance	—	—	-	-	—
N.	Sonography for guidance of other needle aspiration or biopsy	—	-	-	-	—
0.	Sonography for placement of indwelling catheters (nephrostomy, gall bladder)	—	-	—	—	—
P.	Other (Specify): _____	—	—	-	-	—
IV.	MAMMOGRAPHY					
A.	Mammogram interpretation	—	-	-	-	—
B.	Needle localization for biopsy	-	-	-	—	—
c.	Galactography	-	-	—	—	—
V.	S P E C I A L :					
A.	Abscess drainage	-	-	—	-	-
B.	Drainage of fluid collections	-	—	—	-	-
c.	Biopsy/fine needle aspirates	—	—	—	-	-
D.	Arthrography:					
	1. Shoulder	—	—	—	-	-
	2. Wrist	—	—	-	-	-
	3. Knee	—	—	-	—	—
E.	Percutaneous gallstone removal	—	—	—	—	—
F.	Percutaneous nephrostomy tube placement	—	—	-	—	—
G.	Percutaneous biliary drainage tube placement	-	—	—	-	-
H.	Percutaneous transhepatic cholangiography	-	—	—	-	-
I.	Venography	-	—	-	-	-
J.	Other (Specify): _____	—	—	-	-	-

Circular Appendix 95-16-C.11

12/08/95

RADIOLOGY PRIVILEGES REQUEST FORM

1. I hereby request the clinical privileges as indicated on the forms attached.

_____ Applicant _____ Date

2. I **hereby** recommend the clinical privileges as indicated.

_____ Supervisor/Consultant _____ Date

3. As Chairperson of the Medical Staff Executive Committee, I **hereby** recommend the clinical privileges: (Check one)

As noted.
With the following exceptions, deletions, additions, or conditions:

_____ Clinical Director _____ Date

4. I hereby recommend the applicant for clinical privileges.

_____ Service Unit Director _____ Date

5. Privileges are hereby granted: (Check one)

_ As noted.
_ With the following exceptions, deletions, additions, or conditions:

_____ Chairperson of the Governing Body _____ Date

Circular Appendix 95-16-C.12

12/08/95

OMB No: 0917-0009
Expires: 07/31/98

ESTIMATED AVERAGE BURDEN TIME PER RESPONSE

The public reporting burden for completing this information collection is estimated to average 5 minutes. The estimate includes time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to: Reports Clearance Officer, Attention: PRA, United States Public Health Service, Hubert H. Humphrey Building, Room 721-B, 200 Independence Avenue, SW, Washington, D.C. 20201; reference Paperwork Reduction Project (0917-0009). DO NOT SEND COMPLETED FORMS TO THIS~

Circular Appendix 95-16-C.12

12/08/95

OMB No: 0917-0009
Expires: 07/31/98

ESTIMATED AVERAGE BURDEN TIME PER RESPONSE

The public reporting burden for completing this information collection is estimated to average 5 minutes. The estimate includes time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding the burden estimate or any other aspect of this collection of information including suggestions for reducing this burden to: Reports Clearance Officer, Attention: PRA, United States Public Health Service, Hubert H. Humphrey Building, Room 721-B, 200 Independence Avenue, SW, Washington, D.C. 20201; reference Paperwork Reduction Project (0917-0009). DO NOT SEND **COMPLETED FORMS TO THIS ADDRESS**.

SAMPLE

INDIAN HEALTH SERVICE
PATHOLOGY PRIVILEGES REQUEST FORM

INTRODUCTION:

The Pathology Privileges Request Form must be accompanied or **preceded by** a complete application for medical staff appointment, including the necessary supporting documents. Many clinical privileges pertinent to the practice of pathology **are** listed **below.** The request for privileges must reflect both the applicant's and the facility/staff's ability to **carry out** or support the various functions. Documentation of training and/or experience in performing various procedures/modalities must accompany this request. Any additional privileges may be requested on the form or may be presented in an attached list.

INSTRUCTIONS FOR COMPLETING THE FORM

APPLICANT:

With a check mark in the appropriate location, indicate for each item whether you are requesting LIMITED or FULL privileges. LIMITED means that the applicant may function in the area of the stated clinical privileges only under the direct supervision of a provider holding FULL privileges. FULL means that the applicant is entitled to function independently, following standards consistent with the medical community at large. Be sure to sign the request as indicated on **page** 4.

DISCIPLINE SPECIFIC SUPERVISOR OR CONSULTANT:

Indicate your recommendation for each **requested clinical** privilege by placing a check mark in the appropriate location for either FULL, LIMITED, or NOT recommended (NR). Please explain any recommended limitations or denial of privileges on **an** attached sheet. This recommendation is considered by the governing body when granting or not granting privileges.

PATHOLOGY PRIVILEGES REQUEST FORM

	Applicant Requests Ltd	Full	Supervisor/ Consultant Recommends NR	Ltd	Full
1. Autopsies: non-forensic			-	-	-
2. Intraoperative surgical pathology	-		-	-	-
3. Surgical pathology: microscopic examination, gross examination, and diagnosis with report					
4. Cytology: microscopic examination and diagnosis, with report	-				
5. Fine needle aspiration and biopsy: microscopic examination & diagnosis, with report	-				
6. Bone Marrow aspirate and biopsy: microscopic examination & diagnosis, with report	-				
7. Muscle biopsy: light microscopic examination, and diagnosis, with report	-				
8. Muscle biopsy: light microscopic immuno-cytochemistry & for electron microscopic examination & diagnosis, with report	-				
9. Renal biopsy: light microscopic exam and diagnosis, with report	—				
10. Renal biopsy: light microscopic, electron microscopic, immunocytochemistry examination and diagnosis, with report					
11. Neuropathology: light microscopic exam and diagnosis, with report	—				
12. Cytogenetic studies on tissues	-				
13. Forensic pathology	-				
14. Open lung biopsy: light microscopic exam and diagnosis with report	-				
15. Open lung biopsy: light microscopic, electron microscopic and/or immunocytochemistry examination and diagnosis with report	-				

	Applicant Requests Ltd	Full	Supervisor/ Consultant Recommends NR	Ltd	Full
16. Hematology and coagulation	-	-	-	—	—
17. Immunohematology consultation			-	-	-
18. Clinical chemistry consultation	=	r	-	-	-
19. Medical microbiology and parasitology consultation			—	—	-
20. Medical microscopy consultation	1	z	-	—	—
21. Serology and general immunology consultation	-	-	-	—	—

Circular Appendix 95-16-C.12

12/08/95

PATHOLOGY PRIVILEGES REQUEST FORM

1. I hereby request the clinical privileges as indicated on the forms attached.

_____ _____

Applicant Date

2. I hereby recommend the clinical privileges as indicated.

_____ _____

Supervisor/Consultant Date

3. As Chairperson of the Medical Staff Executive Committee, I hereby recommend the clinical privileges: (Check one)

___ As noted.

___ With the following exceptions, deletions, additions, or conditions:

_____ _____

Clinical Director Date

4. I hereby recommend the applicant for clinical privileges.

_____ _____

Service Unit Director Date

5. Privileges are hereby granted: (Check one)

___ As noted.

___ With the following exceptions, deletions, additions, or conditions:

_____ _____

Chairperson of the Governing Body Date